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Washington State Department of Labor & Industries

Review of the Workers' Compensation Program at the Hanford Site

Performance Review Report

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Performance Review Report

EXECUTIVE SUMMARY

Introduction

The purpose of the project is to provide the Washington State Department of Labor & Industries (L&I) with internal auditing services to conduct a performance review and analysis of the Department of Energy's (DOE) process for adjudicating workers' compensation claims at the Hanford Nuclear Reservation.

Project Objectives and Requirements

This project focuses on DOE's administration of its workers' compensation process and activities. This project includes reviewing the reliability, integrity and the efficiency with which resources are employed for adjudicating claims. In addition, this project assesses DOE's compliance with its obligations as a Washington State self-insured employer. This project is also designed to identify possible problem areas, so that suggestions for process improvements can be developed.

Basis for Report

This report is based on the information obtained from three main activities: 1) Review of claim files maintained by CCSI, the DOE's third-party administrator for workers' compensation claims, 2) Interviews with randomly selected, as well as self-selected, injured workers and 3) Documentation of the current Hanford Workers' Compensation program. The various types of information obtained from these three activities were analyzed to form our opinions regarding program performance.

Conclusions and Recommendations

DOE, through its third-party administrator, Contract Claims Service, Inc. (CCSI) operates the Hanford workers' compensation program within expectations for a self-insured employer. However, as in any operation of this type, there are areas in which performance can be improved. Results of the claim file review and the injured worker interviews both indicate an opportunity for more effective and timely communication and improved timeliness of claim progress to final resolution.

Before improvements can be made, the issue of fundamental differences in perspectives between the service providers and the service recipients must be addressed. Activities that result in bringing the two sets of perspectives nearer to one another should be pursued. We believe there is room to create a more realistic set of expectations from injured workers and a more responsive customer service approach by DOE and CCSI. Workers will be well served if they clearly understand the expected timeframes, the information that is required to be obtained by CCSI and how they can best support the system at the very beginning of the claim process. CCSI will be well served by customers who understand how they can best assist in the adjudication and claim management process.

Our recommendations focus on improving the assistance provided to claimants, increasing the frequency and effectiveness of communications and improving the timeliness of claim progress to final resolution. Implementation of the following

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recommendations will address workers' concerns and improve the effectiveness of the process overall.

RECOMMENDATIONS:

- L&I should share best practices with Self-Insured Employers.
- DOE should establish an advocacy function specializing in retiree and elderly issues.
- CCSI should provide advice and consultation during the initial claimant contact. This process should be a formal, standard procedure but the specifics of the consultation should be tailored to the individual's case.
- CCSI should enforce the 24- hour policy regarding initial contact with the claimant. A structured follow-up procedure should be followed.
- CCSI should provide more frequent contact with claimants. Important developments such as action plan delays due to medical information, acceptance and denial decisions, and diagnosis/treatment approvals should be immediately communicated to, or discussed with, the claimant.
- CCSI should contact physicians at the same time as the 24-hour initial claimant contact.
- CCSI should challenge the tone of current correspondence and include explanations of required information. A letter regarding the decision on a condition and approved treatment costs should be added.
- CCSI should enforce the 30-day claim file and action plan review policy.
- CCSI's claim supervisor should focus the review on claims needing extra effort to accomplish timely resolutions.
- CCSI should continue to work toward reducing caseloads to 150 per examiner.
- DOE and CCSI should consider involving employees in periodic discussions regarding emerging customer service issues.

We have discussed the differing perspectives and overall conclusions in the first section of this report immediately following this Executive Summary. Our recommendations are contained in the second section of this report. The core aspects of our work and results are provided in the Information and Analysis section of this report. That section provides the basis for our conclusions and recommendations. As such, an understanding of the Information and Analysis section is required to fully understand why we arrived at certain conclusions and why we offered our recommendations.

Other Information Provided in this Report

A significant amount of information is provided in the appendices to this report. Appendix A provides documentation of the current Hanford Workers' compensation system. It is composed of a series of flowcharts and supplementary narrative discussion for a variety of processes related to the overall system. Appendix B provides a summary of our claim file review results, with our overall opinions as to

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how well each claim was managed and a listing of the pertinent regulatory provisions used in our assessment. Appendix C contains a significant amount of information obtained from our interviews. We were careful to segregate comments from the randomly selected group from those who volunteered to be interviewed. We were also careful to report the interview results in such a way as to protect the confidentiality of the responses. Appendix D provides information about the scope and methodologies used in this project. This appendix is helpful in understanding the project approach and limitations of our performance review.

Conclusion

The Hanford workers' compensation system is complex as it involves multiple compensation programs and multiple contractors with varied perspectives. While the current system should be more focused on customer service, its current operation is within expectations for self-insured employers. To the extent that recommended changes are implemented to improve assistance to workers, improve the effectiveness and frequency of communication and improve the timeliness of claim progression to final conclusion, workers concerns will be substantially addressed.

We wish to thank all of the current and former Hanford workers who were willing to provide their experiences and concerns. We also wish to thank CCSI for their assistance and their patience for our significant disruption while we were reviewing their claim files. We also thank the DOE and its contractors for providing information important to this project and others such as the University of Washington and the US Department of Labor and its contractor, for their assistance in this project. Finally, we wish to thank L&I for providing substantial technical and administrative support, in addition to very valuable project oversight.

March 31, 2006

PERSPECTIVES AND CONCLUSIONS

Introduction

The Washington State Department of Labor & Industries (L&I) engaged our firm to conduct a performance review and analysis of the US Department of Energy's (DOE) process for adjudicating workers' compensation claims at the Hanford Nuclear Reservation. Inherent in a process performance review, and explicitly stated in our contract with L&I, is an assessment of the reliability, integrity and the efficiency with which resources are employed for adjudicating claims and to identify possible problem areas and provide suggestions for process improvements. The nature of process performance assessments involves judgments about how well programs are managed, and in many aspects, these judgments are subjective. The reason for conducting this review and why an independent consultant was used is briefly explained below.

Background

Workers at the Hanford Site have expressed multiple concerns to the Department of Energy (DOE) that claims for workplace injuries are being mishandled. Workers complained of having to hire attorneys to attempt to get some medical claims paid. Other claims, they alleged, were languishing for more than a year before being paid. DOE committed to a review of the third party administrator, Contract Claims Service, Inc. (CCSI) that handles their workers' compensation claims. At issue is whether CCSI is processing the claims as required by state law and doing so promptly while treating employees with courtesy. In order to conduct the review with objectivity and ensure that the results and recommendations are fully credible to the employees, DOE requested that L&I manage the review process. L&I determined that hiring an independent consultant to coordinate the review would be beneficial and increase credibility.

Nature of this Project

A performance review focuses on how well the process works from various perspectives. Efficiency of processes is important to those involved in managing the program. Effectiveness of process outcomes is important to the beneficiaries (customers) of the program. From a performance assessment perspective, all parties involved in any process should be concerned with both efficiency and effectiveness.

While compliance with laws and regulations is an important consideration of assessing performance, it is not the only consideration. From a performance perspective, how well customers are served (effectiveness) and how streamlined (efficient) service processes operate are equally important in assessing performance.

As is evident from the description of the background and reasons for this project, confirmed by our observations and interactions, various parties appear to have a disconnected set of perspectives and expectations regarding both the program and this project. We believe the various parties are well served by an open discussion of these differing perspectives to enhance understanding and possibly affect future process improvements.

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Perspectives of the Program

The fundamental relationship between L&I and DOE is a good place to begin a discussion of perspectives.

The Revised Code of Washington (RCW) 51.04.130 provides for special insuring agreements between DOE and L&I that need not conform to the state's industrial insurance law if the department (L&I) finds it is in the national interest.

The Memorandum of Understanding (MOU) between L&I and DOE states that covered contractors are covered under the MOU as a group as defined under the self-insurance regulations. DOE shall perform all functions required by self-insurers in the State of Washington including maintaining certification requirements and paying required assessments. L&I oversees the provision of benefits to ensure compliance with laws, etc. DOE is not required to file an application for Self-Insurance as the MOU satisfies this purpose.

L&I has significant oversight responsibilities for all self-insured employers in the State of Washington, but is limited in its ability to de-certify an employer or cause corrective actions to be taken by the provisions of RCW 51.14.080 and RCW 51.14.095. Essentially these provisions require severe mismanagement or specific listed behaviors before action can be taken.

This presents an issue as to how this project relates to the fundamental relationship between L&I and DOE. The Hanford workers' compensation program has several unique aspects. DOE and its contractors as a group, is a self-insured employer, with the same responsibilities as all other self-insured employers in the state. As long as DOE operates its self-insurance program within laws and regulations, in all material respects, then of what use is this project? The answer to this question lies in the background discussion above and in L&I's and DOE's agreed-upon response. Workers expressed various concerns about the management of this program. While not definitive, their concerns are an indication of a process that should be challenged. Once again, in order to conduct the review with objectivity and ensure the results and recommendations are fully credible to the employees, DOE requested that L&I manage the review process. The agencies have determined that hiring an independent consultant to coordinate the review would be beneficial and increase the credibility of the review.

Therefore, this project and this report have been designed to address workers' concerns about the effectiveness of the process as well as the compliance aspect of the process. When any program operates with the fundamental objective of compliance with laws and regulations without equal regard to efficiency of operations or effectiveness of outcomes, there will be a disconnect between the process managers and the customers.

The relationship between DOE and CCSI is vitally important to the administration of the self-insured program. This relationship is established by contract. The contract provides for a per claim payment divided between opening a claim and closing a claim. Both of these activities are important to not only DOE, but to injured workers, as long as it is appropriately handled. There is one clause of this contract that aids in the understanding of perspectives.

"The purpose of workers' compensation at the Hanford Site is to provide for appropriate medical care, make benefit payments in a timely manner, minimize disability, and return injured and/or ill employees to the job of injury, other suitable employment within the Hanford Site or other gainful employment. The program will be administered to preserve the assets of the government and its covered site

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contractors. It is the government's policy to pay full benefits as required by Washington State law."

We expect that some injured workers focus on the statement "The program will be administered to preserve the assets of the government and it's covered site contractors" as a directive to CCSI to deny benefit payments. However, this focus without considering the portion of this clause that discusses providing appropriate medical care and paying full benefits under state law, is misplaced. We heard worker comments that CCSI "uses the law" to deny benefits, provided in a negative sense. These comments indicate a misunderstanding that CCSI must follow the law in its claim management activities. However, these types of comments may also indicate a lack of assistance in helping the injured worker to understand the regulatory constraints, so that the injured worker can "use the law" for their benefit. Based on our work, we found no overt pressure on CCSI to improperly deny claims, either contractually or otherwise.

We believe a proactive claims management process that provides frequent communication and assistance to claimants is the best way to provide full benefits and preserve the assets of the government and its covered site contractors. Such a claims management process would also minimize the perception that operating the program in conformity with state laws and regulations does not protect the workers interests.

However, we believe that the DOE and CCSI activities are focused on complying with state law. While this is appropriate, such a focus on compliance should not be the only objective of their activities. Activities designed to manage customer service objectives are also important. Without a sufficient focus on customer service objectives, some employees are dissatisfied and complain.

Workers have a very different perspective of this program. When they are injured or become ill due to what they believe is a work related incident, they expect to be made whole under the state program. They expect this to occur without an involved process on their part (answering questions, filling out paperwork, providing work and medical histories, etc.). They also expect to receive payments, if time-loss is involved, so that they can pay their bills on time.

The state's workers' compensation program provides for time frames to balance the need to promptly process workers' claims with the need to determine the validity of the claim. Even the 60-day requirements to deny claims or pay medical bills are viewed as too long by injured workers.

Activities that result in bringing the two sets of perspectives closer to one another should be pursued. We believe there is room to create a more realistic set of expectations from injured workers and a greater customer service approach by DOE and CCSI. Workers will be well served if they clearly understand the expected timeframes, the information that is required to be obtained by CCSI and how they can best support the system at the very beginning of the claim process. CCSI will be well served by customers who understand how they can assist in the adjudication and claim management process.

Overall Conclusion

The Information and Analysis section of this report contains conclusions specific to the file review and the interview portions of our work. Recommendations that are provided in the next section are based on these conclusions. Our main conclusion

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from the claim file review is that DOE, through its third-party administrator, CCSI, operates the Hanford workers' compensation program within expectations for a self-insured employer. However, as in any operation of this type, there are areas in which performance can be improved. The conclusions from the interview work highlight a need for improved communication of the process, in general, and specifically, more frequent contact regarding the status of injured workers' claims. In addition, the interviews indicate that faster processing of the claim is expected from the workers. We also believe that more assistance, directed toward helping the injured worker to be better able to assist in a successful outcome, is warranted. There were two consistent points that intersected the file review work and the interview work: effective and timely communication and timeliness of claim progress to final resolution. It is interesting how closely the conclusions from this work correspond to the expressed need for this project as previously described in the background portion of this section.

RECOMMENDATIONS

Introduction

This project requires our assessment of the reliability, integrity and the efficiency with which resources are employed for adjudicating claims and to identify possible problem areas and provide suggestions for process improvements. Other than the corrective action plan provisions of RCW 51.14.095, we found no statutory mechanism for L&I to assist self-insured employers in improving their claims management processes. However, since L&I and DOE have cooperatively worked to undertake this project to improve the current situation and to address worker's concerns, we have developed recommendations for that stated purpose. Some of our recommendations are more feasibly implemented than others. As such, we understand that certain recommendations, if pursued on a detailed level, may not be worth pursuing.

RECOMMENDATIONS:

- L&I should share best practices with Self-Insured Employers.
- DOE should establish an advocacy function specializing in retiree and elderly issues.
- CCSI should provide advice and consultation during the initial claimant contact. This process should be a formal, standard procedure but the specifics of the consultation should be tailored to the individual's case.
- CCSI should enforce the 24- hour policy regarding initial contact with the claimant. A structured follow-up procedure should be followed.
- CCSI should provide more frequent contact with claimants. Important developments such as action plan delays due to medical information, acceptance and denial decisions, and diagnosis/treatment approvals should be immediately communicated to, or discussed with, the claimant.
- CCSI should contact physicians at the same time as the 24-hour initial claimant contact.
- CCSI should challenge the tone of current correspondence and include explanations of required information. A letter regarding the decision on a condition and approved treatment costs should be added.
- CCSI should enforce the 30-day claim file and action plan review policy.
- CCSI's claim supervisor should focus the review on claims needing extra effort to accomplish timely resolutions.
- CCSI should continue to work toward reducing caseloads to 150 per examiner.
- DOE and CCSI should consider involving employees in periodic discussions regarding emerging customer service issues.

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Recommendations to L&I

L&I functions in a regulatory role with respect to self-insured employers. The underlying objective of the regulations is to ensure that there is consistency in benefits and program operations between "state fund" employers and self-insured employers. As noted above, we found no statutory mechanism for L&I to assist self-insured employers in improving their claims management processes. Penalties may be assessed for certain regulatory non-compliance, which provides an incentive for properly managing claims. Otherwise, the potential for cost savings and employee productivity will drive self-insured employers' decisions on how they administer their workers compensation programs. L&I has accumulated vast experience in its claims management personnel that could be useful to many self-insured employers. To the extent that this knowledge is transferable to self-insured employers, the overall program would be enhanced. Changes to allow for the sharing of best practices with self-insured employers that require statutory modifications and staffing (budgetary) changes may not be feasibly accomplished. However, to the extent that assistance can be provided under the current regulatory framework, it is worth considering.

Recommendations Regarding Communication and Assistance to Workers

We have provided several recommendations related to improved communication under the claim administration heading below. This section concentrates on recommendations based on the interviews with injured workers. As such, the focus of this section is on recommendations to improve customer service. Considering the different perspectives involved in the program that were previously discussed, these recommendations will likely require a change in culture and attitude.

Retiree and Elderly Issues

As more fully described in the Information and Analysis portion of this report, we observed a significant difference between current (and, therefore, younger) workers and retired (and, therefore, older workers) in terms of support systems available to them. While all participants in the current program would benefit from additional assistance and more effective communication, we believe the needs of the retired and elderly portion of the population is much more pronounced.

We recommend that DOE consider establishing an independent advocacy function charged specifically with outreach and assistance to retired DOE employees. This new "retiree coach" function would have claims examiner qualifications, but would be expected to acquire an in-depth knowledge of all programs affecting retired and elderly participants, such as EEOICP, the Social Security Administration and Medicare, for example. This would help to establish an effective working relationship between current contractors, the Hanford Energy Employees Compensation Resource Center and the Department of Labor with respect to the EEOICP program. Specific activities for this function would be assessing the current status of the claim files in relation to other programs, advising the retired workers as to the likely outcome of the state or EEOICP claims and what actions the retiree might take to enhance their success in the claims process.

We understand that this recommendation comes with significant implementation issues, such as how to contact retirees without unduly raising expectations, relationship with the DOL and its EEOICP program and how to establish and fund such a function while preserving its independence. However, we believe this need is very real and is worth consideration.

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Current Workers

In addition to the recommendations provided under the claims administration portion of this section regarding more frequent communication with workers, we recommend that the initial contact with employees include some time for advice and consultation. The purpose of this additional up-front effort is to engage the worker as a productive partner in the process. Many workers perceive the relationship with DOE/CCSI to be adversarial in nature. To the extent that these workers' perceptions can be changed from an adversarial nature to a cooperative relationship, and result in a more effectively engaged "partner" in the process, improved worker satisfaction, and more timely resolution of the claim should result.

An example of how this concept might be implemented is a checklist used in the initial phone contact with employees that discusses the type of medical evidence and employment information that will be needed to review the claim, the diagnosis and treatment that requires CCSI approval and how effectively that approval is obtained, under which circumstances an independent medical examination might be required and the specifics of how that process works, and any other aspects of the claim process that can be anticipated based upon the initial filing information.

The recommendations regarding frequent communication provided in the following section also address issues noted in the interviews and are not repeated in this section. The first portion of Appendix C provides recommendations offered during the injured worker interviews. Some of their recommendations are consistent with the recommendations described in this section. However, there are several other specific recommendations, not repeated herein, that should be considered.

Recommendations Related to Claim Administration

The following recommendations are based on our assessments of the claim files. Providing information to the claimant early in the claims adjudication process addresses some of the employees' concerns. CCSI has or is making certain changes that are discussed in the Information and Analysis section of this report. We believe those actions should have a positive effect on CCSI's claims management procedures.

Early Contact with Employees

We recommend that the reason for the 24-hour contact with the claimant be reinforced with claims examiners and enforced in practice. The claim file review indicated that from the time the claim was received to the time the examiner conducted an initial review ranged between two to five (2-5) days. We suggest that time-loss claims require a minimum of three (3) attempts over a two-day period and then, if contact attempts are not successful, a letter be sent to the claimant asking them to contact the office. CCSI does attempt to follow up initial calls but more structure in this process should be considered. For medical only claims, other than beryllium, asbestosis and hearing loss, a one-time call/attempt would seem adequate. The beryllium, asbestosis and hearing loss claims should be handled the same way as time-loss claims. The current process of sending initial letters to the claimant should be retained.

Initial Phone Contact with Physician at Same Time as 24-Hour Contact with Claimant.

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We understand that the physicians in the community do not prefer such early contact. However, an initial call would secure records for the industrial injury sooner thus reducing the potential delay between the filing of a claim and the receipt of records that allow for early adjudication. This procedure would likely minimize the perception that CCSI asks the claimant to request the records from the physician. The claim notes indicate that many physician calls were initiated by the physician's office instead of CCSI initiating the contact. Receiving and reviewing medical records early would alert CCSI to the possibility of a prior condition earlier in the claim process. These records should be obtained, in all cases, for sound claims management practices to make early decisions on claims. Besides delayed progress and communication with the claimant, a Segregation Order and Notice isn't requested if appropriate and as a result, DOE may accept a condition unrelated to the industrial injury. Local physicians, including specialists could be sent a letter addressing the need for initial calls and requests to minimize the impact from this change in procedure. Also, for frequently used physicians and emergency rooms, a visit by CCSI to explain the need for early medical reporting may be helpful.

Challenge the Nature and Tone of Current Correspondence

We recommend a review of all initial form letters that are sent to the claimants when a claim is initially filed for sufficiency of information included and the tone of the communication. For example, a simple change from the use of the term "investigation" to "review" in the initial letter may reduce the potential for a claimant's negative impression of the correspondence. Also, in regard to these initial letters, CCSI should explain what information is required to meet L&I requirements and how the claimant might assist in this process. We also suggest that all of the initial letters be reviewed, in relation to one another, to determine whether conflicting information exists.

We recommend that CCSI add a new letter to its standard correspondence regarding the examiner's decision on the accepted condition. The original would be mailed to the attending physician and a copy to the claimant, with a clear explanation of the treatment costs CCSI has approved. This would require the early contact with the physician recommended above and obtaining medical records timely. Also, by sending a copy to the claimant, another means of early communication with the claimant occurs that effectively explains what condition and related costs are being accepted.

Enforce the Diary Expectations Stated in CCSI's Manual.

As discussed in our Information and Analysis section, keeping current on diaries assists the claims examiner in managing the timely progression of the claim. The initial follow-up diary should be set within 30 days and every subsequent 30-day period. This is CCSI's policy and is also contained in their contract with DOE. As such, our recommendation focuses on ways to improve CCSI's compliance with its own policy. The importance of using the diary system to keep current on each claim should be reinforced with employees through office meetings and correspondence. Supervisors should make a concerted effort to review compliance with diary reviews when conducting their review of claims. A specific quality assurance review to determine that this policy is consistently practiced should be conducted until a high compliance rate is consistently achieved.

Risk Assessment Techniques for Claims Supervisor Reviews

As the new Claims Supervisor becomes proficient in claim file review, establishing specific risk-based criteria for the review will enhance the productivity of the review.

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For example, rather than reviewing every claim every 30 days, identified factors, such as the length of time a claim has been open or the total estimated incurred reserve would initiate a thorough and detailed review. While it is important for examiners to review all claims every 30 days, the Supervisor should focus on those claims that need it most. This risk-based approach might allow the Supervisor to be involved in certain claims needing extra effort to accomplish timely resolutions (e.g. hearing loss claims and beryllium claims). More direct supervisory involvement in certain claims would provide consistent claims adjudication and cross training to reduce inherent problems in managing claims with certain risk characteristics.

Other

We understand that CCSI is addressing examiner caseloads. We recommend that the target for caseloads be approximately 150 claims per examiner.

DOE and CCSI meet with contractor representatives on a frequent basis. In addition, we understand that there are certain interactions with union representatives related to safety and workers' compensation program matters. We do not wish to recommend superfluous or unnecessary employee involvement in the program, but organized roundtable discussions with employees to solicit their ideas are helpful in assessing emerging customer service issues. As such, DOE and CCSI should consider engaging their employee customers on a periodic basis for the purpose of identifying issues so that they can be promptly addressed.

INFORMATION AND ANALYSIS

Introduction

The purpose of this section is to describe the information obtained and how it was analyzed. As more fully described in Appendix D Project Scope and Methodology, we used a combination of documentation review, financial and operating data analysis, and discussions with various groups. Some of our work was done on a random basis, using statistical sampling methodology, while other work involved our judgment as to the nature of data accumulation methods.

Information

We obtained the information used in this project from three main sources: documents, data from management information systems and interviews. Documentary evidence used included the workers' compensation claim files maintained by CCSI, laws and regulations for industrial insurance, contracts, informational brochures, forms and other documentation provided by various sources. Operating and data analysis activities were focused on the information that resides in CCSI's claim management system. Information obtained from interviews included the information used to document the process contained in Appendix A. The impressions of the process were provided both by randomly selected current or former workers and by a group of volunteer current or former workers, who wished to provide information. Representatives from DOE and L&I also provided information used in our work.

We randomly selected 48 claim files, and the related claimants to interview, from the population of claims filed during the year ended December 31, 2004. The total number of claims filed during 2004 was 560. We reviewed these files for a variety of attributes and rated specific claims management activities. Of the total of 48 claim files, two files related to ongoing hearing loss equipment needs (hearing aid batteries, etc.). These two claims were not rated as typical adjudication activities and decisions were not relevant to these cases. As such, the highest number of files reviewed for most attributes as provided in Appendix B Summary of Claim File Review is 46. Not all attributes tested were applicable for all of the claim files, so in many cases, the number of files reviewed that were applicable to any given attribute was much less than 46.

Of the 48 claims selected, we interviewed 36 individuals. There were several reasons why the resulting interviews were less than the number selected. There were a few instances where we had selected a deceased person or the person was too ill or frail to be interviewed. There were several instances where the individual was no longer employed at Hanford and had moved from the Tri-Cities area. We were, however, able to conduct a phone interview with some of these individuals. For the few remaining individuals, who declined to be interviewed, and did not respond to follow-up efforts, we cannot provide a reason. While we had planned for an interview sample (our target was 41 interviews, as explained in Appendix D) that would be less than the file review sample of 48, this result affects the precision level of our conclusions provided in the following section.

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Understanding the Results

It is important for the user of this report to understand how closely the sample correlates to the population. To aid in this understanding we provide the following comparison of the sample of claim files reviewed to the 2004 population of claims.

Nature of Claim	Population	Percentage	Sample	Percentage	Variance
Abrasion	5	0.89%	0	0.00%	-0.89%
Allergic derm	1	0.18%	0	0.00%	-0.18%
Angina pectoris	1	0.18%	0	0.00%	-0.18%
Asbestosis	48	8.57%	5	10.42%	1.85%
Beryllium	17	3.04%	3	6.25%	3.21%
Bite/sting	5	0.89%	2	4.17%	3.27%
Burn	3	0.54%	0	0.00%	-0.54%
Burns or scalds	1	0.18%	0	0.00%	-0.18%
Cancer	8	1.43%	1	2.08%	0.65%
Carpal tunnel	17	3.04%	1	2.08%	-0.95%
Concussion	1	0.18%	0	0.00%	-0.18%
Contusion	7	1.25%	0	0.00%	-1.25%
Contusion/crushing	4	0.71%	0	0.00%	-0.71%
Crushing	1	0.18%	0	0.00%	-0.18%
Cut, laceration	9	1.61%	1	2.08%	0.48%
Dermatitis	1	0.18%	0	0.00%	-0.18%
Dislocation	1	0.18%	0	0.00%	-0.18%
Electric shock	1	0.18%	0	0.00%	-0.18%
Foreign body	2	0.36%	0	0.00%	-0.36%
Fracture	7	1.25%	0	0.00%	-1.25%
Hearing loss	119	21.25%	11	22.92%	1.67%
Hernia	2	0.36%	0	0.00%	-0.36%
Hernia and rupture	1	0.18%	0	0.00%	-0.18%
Illness	1	0.18%	0	0.00%	-0.18%
Inflammation	1	0.18%	0	0.00%	-0.18%
Inflammation	26	4.64%	4	8.33%	3.69%
Inguinal single	1	0.18%	1	2.08%	1.90%
Irritation	7	1.25%	0	0.00%	-1.25%
Laceration	1	0.18%	0	0.00%	-0.18%
Malignant	3	0.54%	0	0.00%	-0.54%
Mental disorder	1	0.18%	0	0.00%	-0.18%
Multiple injuries	1	0.18%	0	0.00%	-0.18%
Multiple injury	1	0.18%	0	0.00%	-0.18%
No physical injury	5	0.89%	1	2.08%	1.19%
Not elsewhere	1	0.18%	0	0.00%	-0.18%
Other pneumocon	2	0.36%	0	0.00%	-0.36%
Other skin cond	1	0.18%	0	0.00%	-0.18%
Other toxic	1	0.18%	0	0.00%	-0.18%
Poison:chemical	31	5.54%	0	0.00%	-5.54%
Poisoning	1	0.18%	0	0.00%	-0.18%
Radiation	2	0.36%	1	2.08%	1.73%
Radiation	1	0.18%	0	0.00%	-0.18%
Respiratory	2	0.36%	0	0.00%	-0.36%
Respiratory	2	0.36%	0	0.00%	-0.36%
Rupture	2	0.36%	0	0.00%	-0.36%
Scratches	3	0.54%	0	0.00%	-0.54%
Sprain	9	1.61%	0	0.00%	-1.61%
Sprains, strain	150	26.79%	12	25.00%	-1.79%
Strain	20	3.57%	3	6.25%	2.68%
Symptoms	1	0.18%	0	0.00%	-0.18%
Syno/tendonitis	1	0.18%	0	0.00%	-0.18%
Systemic effect	16	2.86%	2	4.17%	1.31%
Trauma	1	0.18%	0	0.00%	-0.18%
Unknown	2	0.36%	0	0.00%	-0.36%
Upper respiratory	1	0.18%	0	0.00%	-0.18%
Grand Total	560	100.00%	48	100.00%	0.00%

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This comparison shows that the sample closely correlates to the population regarding the nature of the claim. The nature classifications are used in CCSI's system for categorizing the claims it manages. We have highlighted the claim types in which our sample deviated from the population by more than two (2%) percentage points. For example, our sample included a slightly higher percentage of Beryllium, bites & stings and inflammation. The sample included no claims categorized as poison/chemical but 4% of our sample included the systemic effects category. In combination, the sprains/strains and the strain category were close to the population characteristics. Also important to note is that the sample closely resembled the population for major categories such as asbestosis, carpal tunnel, hearing loss and systemic effect.

Another way to assess how closely the sample resembles the population is to compare the type of claim, such as time loss or medical only claims categories used by CCSI in tracking its claims. The following chart presents this comparison:

Type of Claim	Population Percentage	Sample Percentage	Variance
Death claim	4	0.71%	1
Medical only	263	46.97%	22
Permanent Partial	134	23.93%	13
Permanent Total	5	0.89%	0
Temporary Partial	3	0.54%	0
Temporary Total	151	26.96%	12
Total All Claims	560	100.00%	48
			100.00%

Once again, the sample closely resembles the population in terms of the types of claims involved.

Criteria

Understanding the nature of the sample provides a context for the results. Also important to understand are the criteria used to form opinions about how well the claims were managed.

The criteria used to determine whether the system is operating properly are several-fold. The first level of criteria is the rules and regulations related to self-insured employers issued by Washington State. The second level of criteria is our understanding of sound business practices and industry standards. The third level of criteria is the policies and practices of CCSI in managing the DOE's claims administration system and the rules, regulations and policies related to workers' compensation management issued by the DOE and its contractors. These criteria levels are not mutually exclusive, as many of the DOE policies are reflected in the CCSI policies, which in turn reflect L&I's policies and sound business practices.

Overall ratings for individual file reviews is highly subjective, in that our opinion is based not only on procedural matters, but is also based on the appearance of the file, the nature of comments included therein, the nature and tone of interactions and other indicators, all taken together as a whole. While our opinion is subjective, it is based on a consistent set of measurement criteria. The following summarizes our measurement criteria used to form our opinions.

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(1) Excellent: The file thoroughly documents that adjudication issues were anticipated and adjudicated very early in the claim management process. The early adjudication of the file provided early information to the claimant, the attending physician and to the employer. Obtaining necessary information was proactively managed with appropriate diary timeliness. Diagnostic tests, corrective treatments and/or independent medical examinations (IME) were approved, scheduled and obtained in a very timely manner, resulting in timely information provided to the claimant, attending physician and to the employer. Outcomes were appropriate and the claim was closed in the most efficient manner.

(2) Good: The file documents that adjudication issues were occasionally anticipated and adjudicated at a fairly early time in the claim management process. Even though the claim was administered in a reactive mode, the reactive times were fairly prompt. This fairly early adjudication of the file provided information to the claimant, the attending physician and to the employer in a reasonable length of time. Obtaining necessary information was proactively managed, on occasion, with acceptable diary timeliness. Diagnostic tests, corrective treatments and/or IMEs were approved, scheduled and obtained in an acceptable time frame, resulting in information provided to the claimant, attending physician and to the employer in an acceptable manner. Outcomes were acceptable and the claims were closed in an acceptable manner.

(3) Fair: The file documents that adjudication issues were handled reactively, without anticipating issues, but were adjudicated within an acceptable time in the claims management process. The adjudication of the file provided information to the claimant, the attending physician and to the employer on a sporadic basis. Obtaining necessary information was rare in proactive management, mostly reacting to requests, and diary timeliness was sometimes delayed. Diagnostic tests, corrective treatments and/or IMEs were approved on a sporadic basis, resulting in information provided to the claimant, attending physician and to the employer on a sporadic basis. Outcomes were sometimes acceptable, but other times they were not. Claims were sometimes closed timely with a few errors but more often claims were not closed in a timely manner.

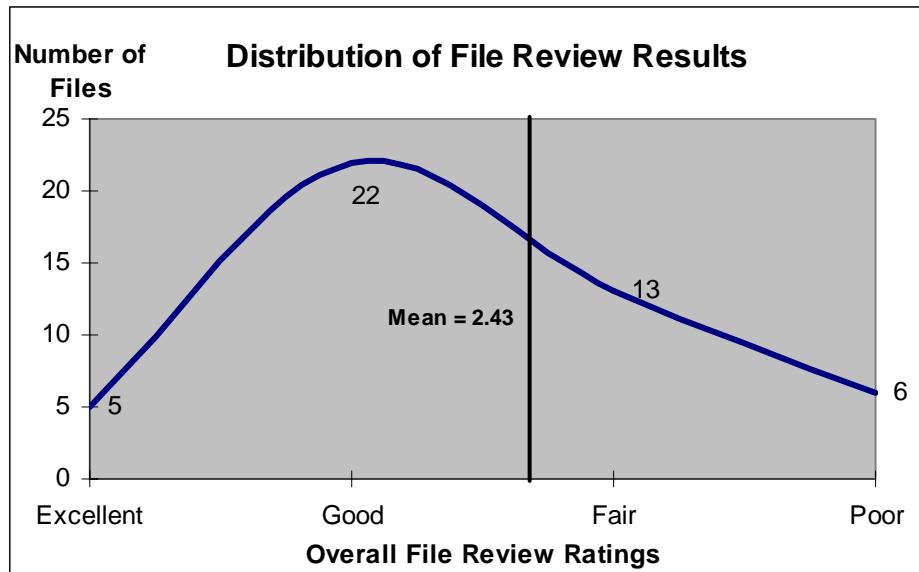
(4) Poor: The file documents that adjudication issues were never anticipated and the claim was not adjudicated within an acceptable time in the claims management process. The adjudication of the claim did not provide information to the claimant, the attending physician or to the employer within an acceptable manner. Obtaining necessary information was not proactively managed, reactive times were slow, and diary timeliness was delayed significantly. Diagnostic tests, corrective treatments and/or IMEs were not approved timely, or at all, resulting in poor, if any, information provided to the claimant, the attending physician or to the employer. Outcomes were not acceptable and claims were not closed timely or properly.

The simple numerical mean (average) of these rating criteria is 2.5. Ratings below 2.5 (i.e., 1 - 2.4) indicate a better than average result, while ratings more than 2.5 (i.e., 2.6 - 4) indicate a worse than average rating. It is important to note that certain claim files may have several excellent ratings and several poor ratings that average out to normal in the overall ratings. The summary of results provided in Appendix B also suffers from the effect of averaging. However, in most cases, the general overall rating of a claim is indicative of each of its components. This makes intuitive sense in that if a case is handled well, each of its components will reflect a proper handling of the claim.

Claim File Review Results

Overall Results

The distribution of the overall results using the criteria described above is summarized in the following chart:



The results indicate that the mean (average) of the assessments were slightly better than the simple numerical mean of 2.5. The results also show that the sample resembles a normal (bell-shaped curve) distribution. The curve is slightly skewed to the left, which indicates that there are more files that received an excellent or good assessment than the number of files that received a fair or poor assessment.

Because the sample was randomly selected and the sample size was determined to be sufficient for a statistical conclusion, we can conclude, with a 90% confidence level, that the 2004 population of claims were managed similarly to the sample claims within a 5% precision threshold. However, it is important to note that this conclusion cannot be made with regard to specific claim management attributes because the sample for certain attributes was much less than required for a statistically valid conclusion. The specific attributes and the number of claim files reviewed for each are provided in Appendix B. Also included in Appendix B are comments provided for each claim file that should assist in understanding the overall assessment applied to each claim file.

We requested and received feedback from L&I's self-insured audit section regarding the information provided in Appendix B. In addition, we provided L&I's Chemically Related Illness (CRI) unit with more detailed assessment information for CRI-type claims included in our file review. We asked CRI unit staff to review our assessments in relation to the information they maintain regarding these same claims. Both of these reviews provided an extra level of scrutiny of our assessments and rating criteria.

We were interested in whether certain claim types or certain injuries/illnesses had different assessment characteristics from the average provided above. As such, we conducted analyses of our assessments and have provided the resulting information in the following two charts.

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Summary of Averages For (Count):					Variance
	Best	Worst	Average	From Mean	
Arms, Shoulders and Upper Extremities (8)	1	4	2.50	-2.68%	
Neck and Back Injuries (5)	2	4	2.80	-15.00%	
Multiple Sprains/Strains (5)	1	4	2.40	1.43%	
Asbestosis and Related Respiratory (5)	1	3	2.20	9.64%	
Other Respiratory/ Radiation (3)	2	4	2.67	-9.52%	
Beryllium (3)	2	3	2.33	4.17%	
Hearing Loss (11 selections, 9 rated)	1	3	2.22	8.73%	
Cancer (1)	N/A	N/A	3.00	-23.21%	
All Other Types (7)	1	4	2.429	0.26%	

This chart provides averages for major groupings of injury types and compares them to the overall sample mean. The variance from mean presented in this chart is based on the mean as 100%. This is important to understand, as what appears as a large variance (e.g. 23%) is only the difference between a "fair" assessment of 3.0 and the mean of 2.435, which is slightly better than the simple numerical mean of 2.5 as previously discussed. In most cases, the claim was administered (on average) similarly to all other cases reviewed, regardless of the nature of the injury. Notable exceptions to this general conclusion are neck and back injuries and the one cancer claim (which also happened to be a pension/death claim). We cross-referenced the individual files included in the neck and back category to the claim status noting these cases have a higher than average open/reopened status, which significantly increases their complexity.

We researched the difference in the asbestosis and related respiratory category and the other respiratory/radiation category of plus or minus 9.5%. We noted a higher degree of involvement by the University of Washington's former Hanford workers monitoring program in the asbestosis and related respiratory category than in the other category. This indicates that the UW program understands the nature of medical evidence required to adjudicate the claim and such information is provided in a timely manner.

The following chart provides a similar comparison regarding the type of claim.

Type of Claim	Count	%	Variance	
			Average	From Mean
Medical Only-Closed	21	43.75%	2.32	4.89%
Medical Only-Denied	12	25.00%	2.08	14.43%
Medical Only-Open/Reopened	6	12.50%	3.00	-23.21%
Medical & Time-Loss-Closed	2	4.17%	3.00	-23.21%
Pension/Death-Denied	1	2.08%	3.00	-23.21%
Time-Loss	6	12.50%	2.67	-9.52%
Total All Claims	48	100.00%	2.43	

Once again, the variance from mean presented in this chart is based on the mean as 100%. As such, a 20% variance is only the difference between an average assessment of 2.5 and a fair assessment of 3.0. Our research into the reasons for these variances provided little additional information. Included in the medical only-closed and medical only-denied categories are all of the hearing loss and beryllium claims, which may have persuasive medical evidence, depending upon the specifics

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of the individual claim. Also, both of these categories are closed claims, which increases the likelihood that they were closed within acceptable timeframes as compared to open or reopened claims. Time-loss claims, as well as reopened claims, add a level of complexity that is not present in medical only claims.

While the analysis indicates that the claim management process is better suited to certain types of claims and certain types of injuries, the variances are not significant and the variances that do exist are partially explained by a variety of factors. This analysis, when considered in relation to the specific aspects of our claim file review, discussed below, indicates a claim management process that is operating within industry expectations.

General Conclusions About Claim Files

The purpose of the claim file review is to determine whether the claims are handled in accordance with the industrial insurance laws and regulations, as well as to determine the reliability, integrity and efficiency applied to adjudication of claims. In addition, the claim file review is designed to identify opportunities for enhancing communication with injured workers, timeliness of activities and decisions, clarity of information provided to injured workers and overall worker satisfaction with the process. As a result, many of our comments in this section of the report are focused on enhancing timeliness, communication and worker satisfaction. In regard to the portion of the review that addresses adherence to the industrial insurance laws and regulations, the findings in this area demonstrate a high level of knowledge of these particular rules and were adhered to on an acceptable level. However, we believe that adherence to laws and regulations is not necessarily a major factor in whether claims are adjudicated efficiently or communication is effective. Claims management strategies and practices greatly influence both the outcomes and the perceptions of the program participants.

With respect to CCSI's claims adjudication process, CCSI demonstrated a high level of understanding of what constitutes a well-managed program. The CCSI manual substantiates this by the standards set forth therein. However, as in any operation, there are improvements that could be made.

Adhering to the industrial insurance laws and regulations communicates to L&I that claims are managed in a regulatory manner. The identification of resources and how those resources are applied to claims is what affects the direct relationship between the claims management firm and the injured worker and the work force of an employer. We noted the following areas of concern indicating potential improvements:

- Inconsistent 24-hour contact with the claimants.
- Delayed diary reviews causing delayed resolution of the claims, thereby causing delayed or no communication with the claimants.
- Delayed requests for medical records, thereby causing delayed resolution of the claim and delayed or no communication with the claimant.

Delayed resolution of claims may increase an employer's liability.

However, in general, the claim files were maintained appropriately. The following comments further explain this conclusion:

- Overall the claims were executed in accordance to CCSI's in-house procedures. The manual was an accurate reflection of best practices commonly used in the industry.

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- Files were in chronological order and neat, which made following the history of a claim easy.
- Claims notes were consistently completed in regard to addressing compensability, the explanation of the working process and the action plans. Phone calls and receipt of medical records seemed to be recorded consistently.
- Supervisor review of new claims, setting reserves, review of letters, and closure and denial requests establish good controls for initial handling of the claims and the closure of the claim. However, a review every 30 days, in accordance with the in-house manual, was not always present in the files.
- The requirement of supervisory and DOE review before changing or deleting a claim note is a good control.
- Medical bills are sent to CCSI's central bill payment function in Dallas for payment twice a week. There is good turnaround by the Dallas office. The examiner usually reviews bills during the update of the file's diary.
- Independent medical examinations (IME) were used sparingly, but appropriately. CCSI is required to obtain DOE's authorization for IMEs as well as any other allocated expense.
- Initial contact with employer/contractor is appropriate and follow-up is done in most cases.
- There was no difference in the handling of Chemical-Related Illness (CRI) claims, including beryllium, from other claim types. Most of these claims were investigated on a medical basis properly and most were allowed and managed appropriately. Those claims that were requested for denial were sent to L&I's CRI Unit.
- Hearing loss claims pose a problem in general because they can require some time to gather prior hearing tests, medical reports and current ratings. In most cases, however, there was not a consistent gathering of information even though most hearing loss claims were accepted.
- We noted that the reserve for a potential hearing loss was understated in several cases. Also, some of the claims were not handled timely and the claimants were not kept advised of the claim's status.

Specific Aspects of Claim File Review

Appendix B provides a summary of the results of the claim file review. We utilized a claim file review program composed of two sections. We review key attributes in the first section provided on the left side of the summary in Appendix B. This review focuses on whether certain attributes are applicable, and if so, whether the file indicates compliance with the attribute. The second portion of the review provided on the right side of the summary in Appendix B, focuses on ten aspects of claim management. It is this section in which we apply the assessment criteria previously discussed.

Also included in our claim file review program is specific information related to the dates of certain activities, the nature and the current status of the claim. This information is useful in determining how quickly certain claims initiation processes were conducted. The Self Insurer Accident Report (SIF-2) was entered into the computer system the day received in the office. The Examiner usually reviewed the claim for initial handling and contact with the claimant 2-5 days later. This does not

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meet CCSI's best practice standard of 24-hour contact with the claimant. This standard has been developed not only by CCSI, but also by many self-insured employers. This best practice standard of early contact with the claimant allows the claim manager to provide information to, and gather information from, that person at the very beginning of the process. This early contact also allows an opportunity to ask and answer questions, to explain the process, and to provide advice and assistance to the claimant to enable them to be a better program participant.

Key attributes included whether time-loss payments were accurate and timely, whether medical bills were paid within the 60-day requirement, and whether denied claims and reopened claims followed the self-insurance rules. The review of the key attributes did not reflect a major problem in any section. However, we did note that compliance with the statutory requirements for submitting a denial was inconsistent. Appendix B contains more detailed information about the results of our review of key attributes.

A fundamental objective of the industrial insurance program in Washington State is to ensure that workers do not experience undue hardship resulting from a work-related injury or illness. Inherent in this objective is that benefits should be paid to only eligible participants with valid claims. Many of the program laws and regulations involve documentation and timeframe requirements designed to strike a balance between reducing hardship and determining claim validity.

Sound claims management business practices share this balanced objective with the program laws and regulations. Regardless of how much any claim management firm's staff explains how a law or rule governs their claim management activities, injured workers may not comprehend what is happening with their claim or why. Laws and rules mean little to the claimant if their benefits are not paid, their inquiries are not responded to in a timely manner or their claim does not progress quickly. As such, the early and effective communication of the program requirements, expected claims adjudication activities, time lines and a full discussion of how the claimant can effectively engage in the process is crucial to managing participants' expectations and perceptions.

There are two attributes contained in our claim file review program and reported in Appendix B that relate to management of claims and financial impacts on employers.

The term "reserves" is used to describe the initial and ongoing assessment of the total expected final cost of each claim. This process is used by insurance companies as well as other entities that manage risks. It is important for these entities to understand the amount that has, or will be, claimed against the organization's assets. We found that CCSI conducted its reserving procedures well. The claim notes commented on the status of the reserves as well as documenting the pro-active evaluation of future reserves.

The term "diary" is used to describe the initial and ongoing tracking of specific information needs and decision timeframes for each claim. Some organizations use a tickler file system wherein any date for an action item can be input, and the item will be automatically shown on the claims adjuster's daily work requirements screen on that date. CCSI's diary system will create some "auto-generated" dates, but the bulk of future review dates are manually entered. We noted a pattern that a significant number of the claims were not diaried and reviewed every 30 days in accordance with CCSI's Manual, or the industry standard. Failure to meet the requirement of a 30-day diary review means the claims adjudicator may have lost some control of the claim. If control is lost, claim costs become more difficult to manage.

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Effective uses of diary systems also have an impact on customer service. When there is a lack of communication with the claimant either by letter, form or phone call on a frequent and consistent basis, the claimant is left wondering about the status of the claim. Then when they do receive notices or letters, usually by mail, they are surprised, don't understand what is being communicated, and therefore, have a negative reaction to the specific communication or the process as a whole. Poor diary and communication control causes poor communication and increases the likelihood of dissatisfaction with services.

Regarding the ten aspects of claims management the following comments are provided.

1. **Contact Control:** Physicians/vendors were not contacted on an early, regular basis. CCSI's Manual does not advise to contact the physician at the initial claims review. CCSI staff represented that the primary reason for this is because the physicians in the community preferred no such contact. The Tri-Cities area has relatively few medical providers in comparison to large metropolitan areas. While it is important to maintain a positive working relationship with the local medical providers, failure to make early contact did create delay in many of the claims.

The claim notes did reflect incoming phone calls from claimants, physicians, therapists, etc. However, there were not many outgoing calls made. It is acceptable that a medical only claim would not require as much communication with the claimant as a time-loss claim as long as the medical only claim is handled in a timely manner.

2. **Medical Control:** There were action plans in each claim files. However, in many cases medical reports were not requested early in the claim. The files often reflected that the Examiner did not proactively pursue these necessary medical reports. In a few cases (2-3 claims), the claimant was asked to contact the physician asking them to send the records to CCSI. This means that activities, which would speed the claim adjudication process, were suspended until such time that the medical reports were received.

This issue is directly connected to the problems with the actual diary review, previously discussed. If the claims are not reviewed timely, reports that have been received can be available, without action, for a longer period of time than appropriate, thereby delaying the claim's progress to ultimate resolution. Timely medical case management cannot be accomplished if the files are on a delayed diary system.

We noted a pattern that indicates that the necessary medical information needed was not consistently requested or anticipated timely. This increases the possibility of a costlier claim and delays in adjudication. The claimant will understandably view long periods without any communication or a final claims action with no explanation as to the delay in adjudication, as inept management or obstructionist behavior. While we believe that the diary and medical control significantly influenced our assessments of certain claims, our overall assessment of proactive versus reactive adjudication exactly matched our overall claims assessment average of 2.43. As such, the comments in the section of our analysis should be placed in the proper perspective that more claims were handled well in this regard than the number of claims not handled well.

3. **Return to Work:** Very little exposure to this issue was present in our sample. The exposure present was handled appropriately.

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4. **Litigation:** Very little exposure to this issue was present in our sample. Three files noted litigation. One was handled well, one was adequately handled and one was handled poorly. The sufficiency of the file for litigation purposes and the support provided to legal counsel were the main criteria for our assessment in this area.
5. **Claim Closure:** For the most part, the claims were closed timely and administered properly. However, there were a few that weren't handled well because of the diary review system issues previously discussed. Poor or untimely closure procedures also affect claimants' perceptions of responsiveness.
6. **Supervision:** CCSI has a procedure in place for a supervisor to review every claim every 30 days. This procedure was either not accomplished or documented in the majority of the claims.
7. **Reserves:** As noted above, CCSI managed its reserving procedures very well.
8. **Client Relations:** Procedures established between DOE and CCSI are consistently followed.
9. **Order and Notices:** No significant issues were noted.
10. **Overall Cost Effectiveness:** If a claim was not handled on a timely or proactive basis the cost effectiveness was challenged and rated below a "good". However, the overall average of 2.43 indicates that more claims were handled well than claims that were not.

Review of Operating Reports and Statistics

CCSI provided several reports for the purpose of reviewing trends. The following presents the total 2004 claims and the proportion of time-loss (TTD) to medical only (MO) claims.

	<u>TTD</u>	<u>MO</u>
New Claims and Re-opened Claims filed in 2004	560	
New TTD claims filed plus claims re-opened in 2004	165	
New MO claims filed plus claims re-opened in 2004	395	
Ratio of TTD or MO claims to total new and reopened claims	29%	71%
Closed Claims	433 Closed of 560	77%

We consider the industrial insurance management industry's normal ratio to approximate 25% of TTD claims and 75% of MO claims to total claims. This industry benchmark has been developed over time within the insurance industry, similar to the development of best practices encouraged by insurance brokers and claims managers over the years. The above ratio for the 2004 Hanford workers' compensation program approximates the industry average. Normally, new claims are only those that are reported in a given year and do not include re-opened claims. The DOE/CCSI statistics include re-opened claims. This difference makes comparisons of ratios difficult. We use the DOE/CCSI classification scheme in many of our analyses, as such, for consistency purposes, we did not pursue an analysis eliminating the re-opened claims from the 2004 opened claim number used.

Percentage of all 2004 claims with denials to total claims

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111 denied claims of 560 new claims 20%

A 20% ratio of denied claims to opened claims is slightly more than our expectation of 15-17%. We obtained the denial rate from L&I's data for 2004 to use as a general comparison and to support our expectation. The results are as follows:

	<u>Filed</u>	<u>Denied*</u>	<u>Ratio</u>
State Fund Claims	139,076	16,893	12%
Self-Insured Claims	55,487	5,690	10%

*Based on the current status, which does not include claims originally denied which were later accepted, nor does it include denied claims where the denial decision is pending and could still potentially be overturned.

There are a few factors, which may explain this difference. These factors include the existence of external programs that encourage the filing of certain claim types listed below. One such program is the Former Hanford Workers Monitoring Program that is documented in Appendix A. Another factor that may influence the denial rate is that certain types of claims present challenges in documenting medical condition and work causation. For example 12% of total claims were denied in four categories as follows.

Denial Rate % to Total Opened Claims

Beryllium claims	1.25 %
Asbestosis claims	2.68%
Chemical and Chemical Compounds	3.39%
Hearing Loss claims	5.00%

Percentage of Chemical-Related Illness (CRI) and Hearing Loss (HL) claims denied in relation to total claims filed in 2004

41 CRI denied claims of 560	7%
28 HL denied claims of 560	5%

There were 119 CRI claims filed in 2004, which represents 26% of total claims. The cause codes used for this analysis are Asbestosis, Beryllium and Chemicals and Chemical Compounds.

Operational Considerations

An understanding of the operational environment that existed during 2004 is important to provide a frame of reference or a context to our assessments previously discussed. This understanding is also important in forming our recommendations. Based on our discussions with CCSI, the following affected their operations during 2004.

CCSI did not have a stable work force during 2004. The loss of one examiner required the use of temporary help for a period of time. In addition, there were extended personal leaves of the manager and senior examiner positions during 2004. This situation created a caseload of 180 to 200 per examiner, which is considered an excessive caseload by industry standards. The industry standards have been significantly influenced by a study done in the State of California regarding workable caseloads. Eventually CCSI replaced the unfilled examiner position and added a new examiner position.

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Excessive caseloads require increased supervisory review and oversight. The combination of excessive caseloads with a temporary absence of sufficient supervisors' regular and consistent claims review can cause many difficulties. These difficulties could include delayed diary reviews and the resulting lack of timeliness of certain claim management activities. This situation can also create problems in effective communication.

This set of circumstances helps to explain some workers' perceptions that they were shuffled between examiners and that frequent changes in CCSI's staffing were frustrating to them.

Changes that occurred in 2005 and 2006

CCSI informed us that they are responding to the operational constraints experienced during 2004. The following actions were discussed.

- CCSI achieved stable and sufficient staffing levels.
- A procedure was established in late 2005 that requires the examiners to call the claimant on every diary review.
- All phone calls are recorded. A procedure to analyze those calls is currently being established and will be finalized by April. The recorded calls will be reviewed by CCSI's Quality Control function.
- Examiner staff is scheduled to, or they are taking, the Washington Workers' Compensation Professional training, as well as the Washington Self-Insurers Association training.
- All employees will be attending a communication seminar.
- The Senior Claims Examiner was promoted to Claims Supervisor in September 2005 with the intent of increasing the oversight of claims on a regular basis.
- From the staffing issues experienced in 2004, CCSI determined a need for cross training of all examiners to cover all types of claims. Consequently, in 2005, the manager began assigning all types of claims to all examiners, based on the individual's caseload in an attempt to keep the caseloads even between examiners.

As noted in the Recommendations Section of this report, we believe these actions should have a positive effect on CCSI's claims management procedures.

Summary Conclusions from Claim File Review

The results and statistics discussed in this section reflect a claims operation that meets industry standards. However, we believe there is substantial room for improvement in more frequent and effective communication with injured workers and better management of the timeliness of claim progress to final resolution.

Interview Results

Appendix C provides a summary of the substantial amount of information obtained from the interview process. We have segregated the comments provided in Appendix C between the randomly selected group and the self-selected or volunteer group. The interview process was designed to focus on individual components of

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the overall workers' compensation program. Individual components include the DOE contractors' workers compensation representatives or other involved employer representatives (e.g. safety or management functions), initial medical providers such as Advanced Med Hanford (or its predecessor, Hanford Environmental Health Foundation), the medical provider community, CCSI, independent medical examination providers, EEOICP/DOL, and L&I. In total, we interviewed 61 individuals.

In connection with the claim file review, we randomly selected 48 files to be reviewed and scheduled interviews with the individuals related to those claims. We interviewed 36 randomly selected individuals who had filed a claim during the year ended December 31, 2004. As previously discussed, there were 12 individuals who did not participate in the interview process for a variety of reasons. Some individuals did not respond to all of the questions, also for various reasons. Of the 36 randomly selected individuals interviewed, 32 provided numerical ranking of their satisfaction with various program components.

We also interviewed 25 individuals who had volunteered to provide their impressions of the process. We received the names of these individuals from three sources: L&I, HAMTC (a union organization for workers at Hanford) and DOE. Included in the volunteer group, were a few individuals who contacted us directly.

Groups Interviewed And Their Expressed Level Of Satisfaction

Comparisons of satisfaction ratings between the random and the self-selected group are as follows (scale of 1 to 10: 10 being the best possible response and 1 being the worst possible response):

Satisfaction Rating Component	Random	Self Selected
1. The case management of your worker's compensation claim	6.06	1.89
2. Your health care treatment	8.03	7.39
3. Your workplace accommodations	8.30	5.09
4. The processing of your worker's compensation claim	6.97	2.61
5. The assistance provided by your company (contractor or subcontractor)	6.96	4.00
6. Help in resolving disagreements related to your claim by L&I or others	5.88	4.90

Was this the first time you ever filed a claim? Yes reported

21 out of 31 2 out of 23

There are two areas of consistency between the two groups. The respondents' level of satisfaction with their healthcare treatment and L&I's help in resolving disagreements are relatively consistent between the two groups. The assistance provided by the company and workplace accommodations varied by about three grading points. The assessment of case management and claims processing activities varied by about 4 grading points.

We expect that most readers of this report assume that the reason workers asked to be included in the interviews is because they experienced difficulty with the process. In addition to that important consideration, are two other factors that we consider significant. Unlike the random group, the self-selected group may have had claims process experience from several years before 2004 or may have had recent (i.e., 2005) experience. The other major factor is that almost the entire self-selected group had prior workers' compensation claims experience. As in all questions, there were some respondents who did not answer this question. This explains why the count reflected in the chart above is 31 for the random group and 23 for the self-selected group.

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These two groups have some similarities. Both groups included a mix of current, former and retired workers. Both groups had experience working for various contractors in various locations at the Hanford site. All individuals had direct experience in the process from filing claims, and both groups, taken as a whole, could comment on the major process components.

Correlation to File Review

We were interested in understanding the correlation between the satisfaction ratings provided above and the results of the file review on an individual basis. We were also interested to understand how the randomly selected individuals, who did not participate in an interview, might have affected the results. Since we had accumulated information for each randomly selected claim, we were able to use this information to enhance our understanding.

Since the file review assessment focused on CCSI's process, a correlation of interview satisfaction with the file review is only relevant to the case management and claim processing questions above. In order to address the different rating schemes between the file review (1, excellent to 4, poor) and the interviews (10 is the best rating to 1, the worst rating), we converted the interview ratings to a 1-4 system. We compared the results for each file for questions 1 and 4 above to the overall claim file review assessment. The results are summarized in the following

Category of Comparison (negative numbers indicate that the claimants' perceptions are worse than our assessment of the file.)	Variance		
	Case Management	Claims Processing	Count
Consistency Between Claimant Perceptions and File Documentation	0.040	0.122	10
File Documentation is Better than Claimant's Perception of the Process	(1.900)	(1.300)	4
Claimant's Perception of the Process is Better than File Documentation	1.429	1.725	17
Claims Where Case Management was Worse and Claims Processing was Better than Perceptions	(0.500)	1.100	1
Average Converted Interview Ratings-All Files	2.1	1.7	32
Total all Files Related to Interviews chart.	2.6	2.6	32

This analysis indicates that one-third of claimants' perceptions of their level of satisfaction with the case management and claim processing functions were essentially the same as our assessment of the claim file documentation. One half of claimants' perceptions were more positive than our assessment of the claim file. In four cases (12.5%), we assessed the file documentation as excellent or good, when the claimant perceived these functions from fair to poor. While not a high correlation, there is correlation between the file documentation and the workers' perceptions. In Appendix C, the random group interview comments related to CCSI are segregated from other process components. There are many positive as well as negative comments made. However, the number of comments that there was little or no contact with CCSI is interesting and highlights a difference between the two sources of information. While a lack of contact would be one negative factor in our assessment of the files, it may be that the injured worker views this positively. The result provided in the above analysis, highlights that activities designed for

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compliance with regulations are likely less important to injured workers than activities designed for customer service objectives.

Also noted in the chart above is that the files for which interviews were conducted averaged a 2.6 assessment when the average for all files were 2.435. This suggests to us that the files related to the people that did not participate were generally, if only slightly, better than the entire sample. In order to determine what affect the "non-interviews" have on our analysis, we conducted an analysis of just those files as is presented in the following chart.

Type of Claim	Count	%	Average	Total Sample	
				%	Average
Medical Only-Closed	6	50.00%	2.25	43.75%	2.32
Medical Only-Denied	1	8.33%	1.00	25.00%	2.08
Medical Only-Open/Reopened	2	16.67%	2.50	12.50%	3.00
Medical & Time-Loss-Closed	0	0.00%	N/A	4.17%	3.00
Pension/Death-Denied	1	8.33%	3.00	2.08%	3.00
Time-Loss	2	16.67%	2.00	12.50%	2.67
Total All Claims	12	100.00%	2.20	100.00%	2.43

Except for the one death claim, all assessments of file reviews for those who did not participate in interviews were better than the total sample. Also notable is that the percentage of denied claims were much less than the sample. Regarding the type of injury for those who did not participate the following is provided.

Summary of Averages For (Count):	Count	%	Average	Sample	
				Average	
Arms, Shoulders and Upper Extremities (8)	2	16.67%	1.50	2.50	
Neck and Back Injuries (5)	1	8.33%	2.00	2.80	
Multiple Sprains/Strains (5)				2.40	
Asbestosis and Related Respiratory (5)	2	16.67%	2.00	2.20	
Other Respiratory/ Radiation (3)				2.67	
Beryllium (3)				2.33	
Hearing Loss (11 selections, 9 rated)	3	25.00%	3.00	2.22	
Cancer (1)	1	8.33%	3.00	3.00	
All Other Types (7)	3	25.00%	2.33	2.43	

Except for one hearing loss assessment (two hearing loss claims were not rated) the assessments were better for these files than for the sample average.

Worker Perceptions of the Claims Process

We listed recommendations that workers had to offer as the first part of Appendix C because their recommendations focus on their major concerns. Most recommendations from the random group involved enhancing communication or the working relationship with CCSI. The second major topic was medical issues such as understanding work hazards and related medical treatment capacity and employers involvement in both the safety aspect as well as the claim aspect.

The major topics from self-selected recommendations can also be categorized into communications and medical issues but the focus is different in that there are more comments regarding timeliness of communication and processing. Also the self-selected group has several recommendations related to the organization of the

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workers' compensation program that are comments rather than recommendations. Essentially these comments focused on replacing CCSI or reverting to L&I's state fund. There were a few comments about DOE in relation to workers' safety concerns.

The worker satisfaction ratings with various components previously provided indicate a sharp contrast between the random group and the self-selected group, especially regarding their employers and CCSI activities. As discussed in Appendix C, how well each step in the process was handled by the applicable organization or individual affects the injured worker's perception of how well the process worked for them. For example, in some cases all points in the process worked well. In these cases the injury or illness was taken seriously by the immediate supervisor, the initial medical treatment was provided timely and was effective, the employer representative was positively involved and helpful, ongoing medical treatment was helpful, the claim was processed timely, the time loss or medical bills were paid promptly, the independent medical examination was professional and helpful, the claim was closed appropriately and the injured worker was treated well in all aspects of the process. Unfortunately, in other cases very few of these process components worked well. When many components fail for any individual claim, the injured worker's perception of the process is understandably poor.

Based on our interviews, we believe this discussion of component success or failure is the reason for the sharp contrast between the random group and the self-selected group. In addition, when the workers perceive that many components have failed, they tend to rationalize the events in a more "conspiratorial" framework. We believe that this framework used to judge their specific cases tends to reduce the satisfaction level of all components. This belief exists in a significant portion of the self-selected group and is evident in their comments. While this belief is present in all of the component comments from this group, it is most clearly evident in the discussion of independent medical examinations provided in Appendix C.

We did not find this phenomenon at work with the random group. The range of satisfaction ratings, as well as their comments, was more closely grouped around a better than average satisfaction level. This indicates that even though the random group had satisfaction issues with various components, those issues did not appear to affect their ratings of other components.

We observed a significant difference in both the random selection and the self-selected group of interviewees between current (and, therefore, younger) workers and retired (and, therefore, older workers) in terms of support systems available to them. While certain DOE contractors manage retirement programs for former workers, these workers were generally unaware of support that they might receive from current contractors. In some cases, these individuals worked for employers no longer present at Hanford, and they did not know that current contractors may have assumed responsibility for them. In addition, many retired individuals were also involved in the EEOICP program and experienced significant confusion about how the various programs interact. In a few cases, these individuals were very elderly, frail and confused. In contrast, current workers have a union support system and employers with personnel known to them, that manage a variety of benefit programs that can be coordinated. While all participants in the current program would benefit from additional assistance and more effective communication, we believe the needs of the retired and elderly portion of the population in this area are much more pronounced.

We analyzed the satisfaction rating from the random group between claim types. Specifically, we were interested in assessing the affect of denied claims in the satisfaction ratings. While denied claims did reduce satisfaction levels by about one

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rating point out of a scale of 10 (10 is best and 1 is worst) in comparison to medical only closed or closed time-loss, it was about the same as open medical only claims. As such, the fact that a claim was denied does not appear to be a significant indicator of satisfaction ratings.

This result is consistent with customer satisfaction studies conducted for L&I regarding its state fund program. L&I provided us with the results of their survey, noting the following concepts that we believe apply to our interview results.

- Both medical only and time loss workers' satisfaction directly related to whether they felt that the claim decision was fair, and that everything went smoothly for them. Other drivers behind the satisfaction level for medical only workers were the ease of getting their claim accepted and bills paid. Similarly, time loss workers' satisfaction with the process was high when it was easy to get payments started and payments continued on time for as long as needed.
- A positive perception of claim services overall is directly related to timeliness of the process and timeliness of returning calls, as well as related perceptions that the claims manager cares about the worker (encourages questions, answers questions, protects work interests, is easy to reach and handles claims in a timely way).

The collections of comments in Appendix C illustrate these concepts. Comments were positive when the result was fair, the process went smoothly, bills or benefits were paid timely, phone calls were returned promptly and the claims examiner was helpful. Negative comments centered around unfair results, long processing times, lack of or poor communication, bills and benefits not paid timely and a perception that the claims examiner did not care, and was therefore, unhelpful.

Worker Perceptions of Other Matters

Our interview participants also provided comments about other aspects of the claims process.

EEOCIP and the US Department of Labor

Individuals involved in the EEOICP program generally appreciated the Resource Center staff because they helped them work through the paperwork and treated them well. However, after this initial part of the process, the comments are generally not favorable due to lack of communication, lack of progress on their claim for long periods of time and unsatisfactory communication with claims adjusters. Individuals who had direct experience with the EEOICP program raised many of the same issues reported in the *2005 First Annual Report to Congress* issued by the Office of the Ombudsman, Energy Employees Occupational Illness Compensation Program, Part E. We obtained this report after we had conducted the interviews and compared our results with the findings contained in that report. The following topics extracted from this report are consistent with what we heard in our interviews:

- Workers experience frustration at the lack of records concerning the covered employee's exposure to toxic substances because records were not maintained at the time of exposure, were lost or destroyed. Claimants feel that their burden of producing pertinent exposure and medical records is an insurmountable one.
- Part B claimants often do not discern a difference between Parts B and E, finding the two programs to be indistinguishable. Claimants have expressed their concern about not being sure whether they have filed a Part B and/or a Part E

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claim; this confusion is sometimes due to unclear communication from the District Offices.

- Claimants who originally filed with the Department of Energy under Part D are frustrated at the years that have gone by without their claim being adjudicated. Many of the claimants are elderly; some are dying. This has resulted in the perception among claimants that the agency is delaying the payment of benefits in an effort to wait for them to die.
- Calls to their Claims Examiners are not always being returned. When calls are returned, it is often by a different Claims Examiner, who has no in-depth familiarity with the file and is unable to provide current information.
- Claimants are encountering great difficulty in finding qualified physicians to perform medical impairment ratings. Likewise, claimants use personal physicians who are unwilling to accept the Medical Benefits Card.
- During its first year of administration of Part E, the Program Agency has focused on paying clear-cut claims. The means used to accomplish this objective was to pay claims for which neither a Wage Loss calculation nor a Medical Impairment rating was required. Since these were the two components that comprised Part E compensation awards to living employees, this meant that no living employees would be paid in the first instance.

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L&I received mixed comments ranging from being very helpful and responsive to being unresponsive and limited in their ability to help. L&I received good comments when they corrected a situation that the injured worker perceived to be unfair, and then the process began to work more smoothly. L&I received poor comments when the worker perceived that L&I works too closely with CCSI, and therefore, doesn't provide an adequate challenge to CCSI conclusions.

University of Washington's Former Hanford Workers Monitoring Program

The UW Former Hanford Workers Monitoring Program was mentioned several times. This program also received mixed reviews. In cases where the UW essentially managed the claim process, the results of diagnostic tests showed some issues, and those issues could be related to work, the individuals had positive perceptions. However, there are a few cases when the diagnosis was uncertain or causation to work was not determinable. The individuals in these situations were not pleased with the program. In essence, these workers felt that it was not worth going through the process just to confirm that there was nothing wrong.

Other

The self-selected group indicated a potential issue regarding the local medical community's unwillingness to accept L&I (CCSI) claims, which they attributed to poor medical provider relations or poor payment management. Since this potential issue could be important to this project, we contacted all nine providers listed in the local Yellow Pages under an "Occupational Health" category and explained the purpose of our inquiry. All nine providers responded that they do not refuse L&I or CCSI claims (referred to as claims from Hanford). Some indicated that they require a primary care physician's referral, and others stated that they would only take new cases that fit with their area of practice. One respondent indicated that many family physicians would not accept new claims, not because of program issues, but because the nature of certain conditions falls outside of their area of expertise.

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This issue appears to be connected to the EEIOPC program issue, regarding sufficiency of medical providers previously discussed, since several self-selected interviewees also had EEOICP involvement.

Based upon these responses, the management of the program does not appear to reduce medical care available to workers, and therefore, no further investigation was considered necessary.

Summary Conclusions from Interviews

Once again, the interview process is designed to elicit perceptions and identify issues and trends in the Hanford workers' compensation program. While the results of the randomly selected group are more representative of the population of claims, the perceptions of the self-selected group are equally valid, even if they are less representative. Both groups highlight a need for improved communication of the process, in general, and, specifically, more frequent contact regarding the status of their claim. In addition, these interviews indicate that more timely progress of the claim is expected from the workers.

Documentation of Current Process

In addition to claim file review and interview activities, this project required documenting the current status of the workers' compensation system at Hanford. This objective was accomplished with the use of flowcharts and narrative descriptions of the current process that is provided in Appendix A. The functional organization structure provided at page A-2 captures the major participants in the process, but not all participants. There are many different entities involved in the workers' compensation system that affects some or all injured workers, and these entities are all involved in various activities.

The process documentation provided in Appendix A is designed for L&I's use, to help it understand how the various entities and processes fit into the overall system. As such, it is not designed to be documentation of a detailed step-by step process, rather a general picture of the main processing components.

Some of the information used to develop the process descriptions in Appendix A was obtained from the file review and interview activities. However, most of the information was obtained from brief interviews with representatives of various entities and a limited review of documents. All individuals who provided information in interviews were provided initial flowcharts and narratives to challenge the accuracy of the information. However, we did not receive feedback from some sources. As such, there are likely to be some errors in the process documentation, but we expect that such errors are of a detailed nature and would not significantly influence the overall picture presented.

The following organizations provided us with the information used in Appendix A.

- Five DOE contractor representatives identified as primary points of contacts for workers' compensation. This group did not include all DOE contractors. This group provided the portion of the process related to their claims management practices.
- Advanced Med-Hanford regarding its injured worker intake process.

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- CCSI management regarding its initial and ongoing claims management processes.
- The Hanford office of the Energy Employees Compensation Resource Center, regarding EEOICP.
- The US Department of Labor, Seattle District Office regarding EEOICP.
- The University of Washington Former Hanford Workers' Monitoring Program.

In addition to these sources, DOE and L&I answered questions related to the processes. L&I also provided relevant forms and background information for our use in developing the process descriptions.

From a process improvement perspective, the number of interdependent process connections (information flow that depends on others) is excessive for an efficient operation. However, this is a reality of the Hanford site. Reducing the number of such connections is not advised, in this particular situation, because the information by each connecting organization is necessary for proper claims management and is not redundant. Given that myriad processing connections and interdependencies is required under the current operating environment, improvement strategies are best focused on enhancing the effectiveness of the interdependent information flows as opposed to reducing the number of interdependent process connections. As a result of this assessment, the recommendations provided in this report are focused on improving the effectiveness of communication and not on streamlining processes.

Appendix A: Process Documentation

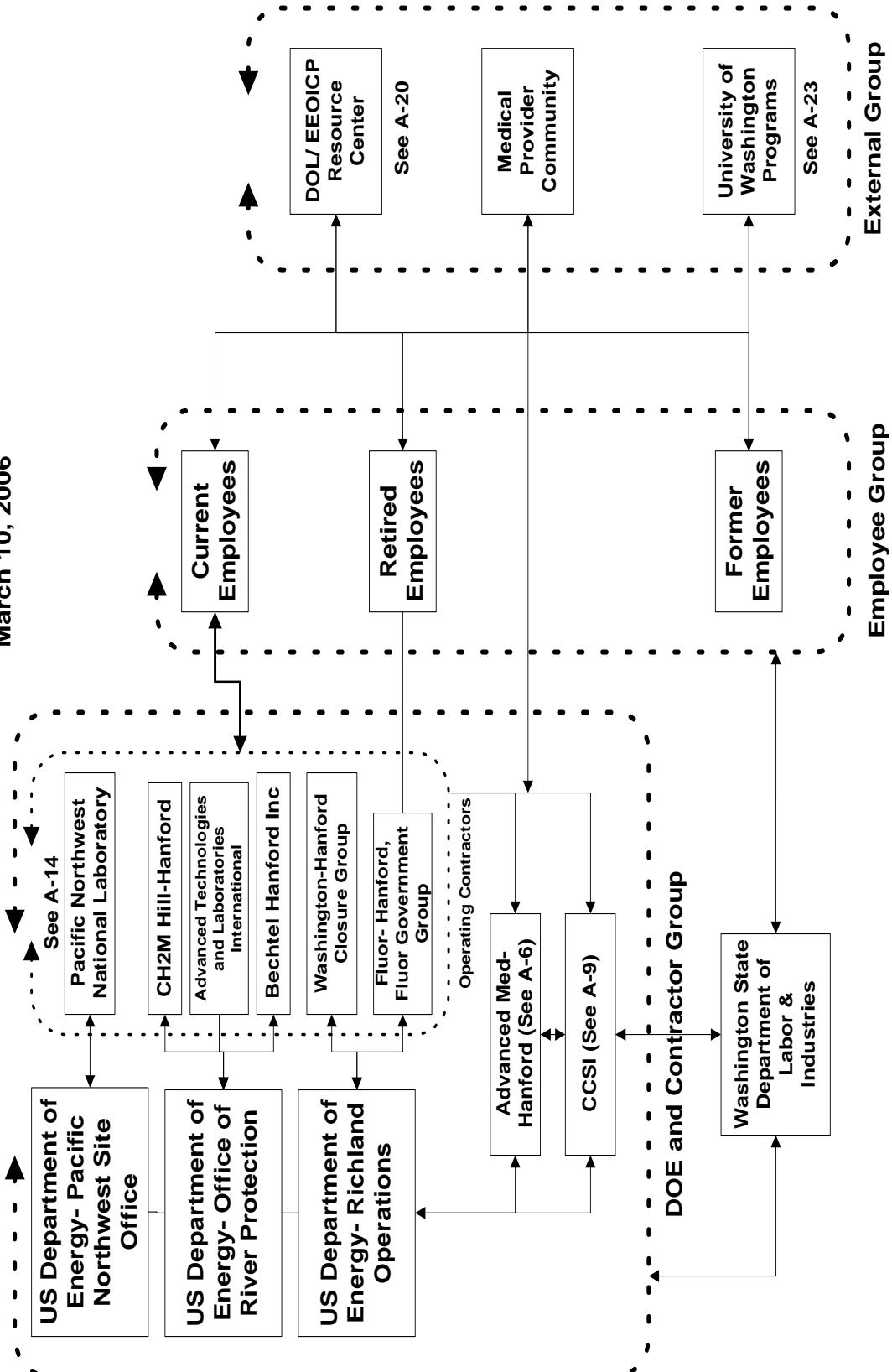
Introduction to Process Descriptions

Appendix A provides a collection of process descriptions for various components of Hanford's workers' compensation program. As is noted in the first chart regarding the functional organization of the workers' compensation program, there are many entities that are involved in various ways. This first chart may be used as a table of contents for the remainder of Appendix A. This documentation is designed to take a process view, i.e., what are the steps in the various processes that are included in the workers' compensation program. These process descriptions focus on major activities and do not attempt to describe all activities or decision points that might be involved in administering the program.

Definitions of Undefined Abbreviations:

AP	Attending Physician
AMH	Advanced Med Hanford (successor to Hanford Environmental Health Foundation (HEHF))
CA	Claims Adjudicator (or Adjuster)
DOE	U.S. Department of Energy
EEOICP	Energy Employees Occupational Illness Program
ER	Emergency room at a hospital
IH	A company's industrial hygiene department or function
IME	Independent Medical Examination
IW	Injured Worker, who is the Claimant
O&N	Order & Notice (issued by the Washington State Department of Labor & Industries (L&I))
OHSA	Occupational Safety and Health Administration
PIR	Physician's Initial Report
POC	Employer's (Contractor's) Point of Contact for Workers' Compensation matters
PT	Physical Therapy
RTW	Return to Work
ROV	Record of Visit
SI	Self Insured (as it relates to workers' compensation matters)
SIF	Self Insurance Form (various form numbers for various purposes)
TTD	Temporary Total Disability (Time-Loss benefits)

Hanford Workers' Compensation Functional Organizational Structure
March 10, 2006

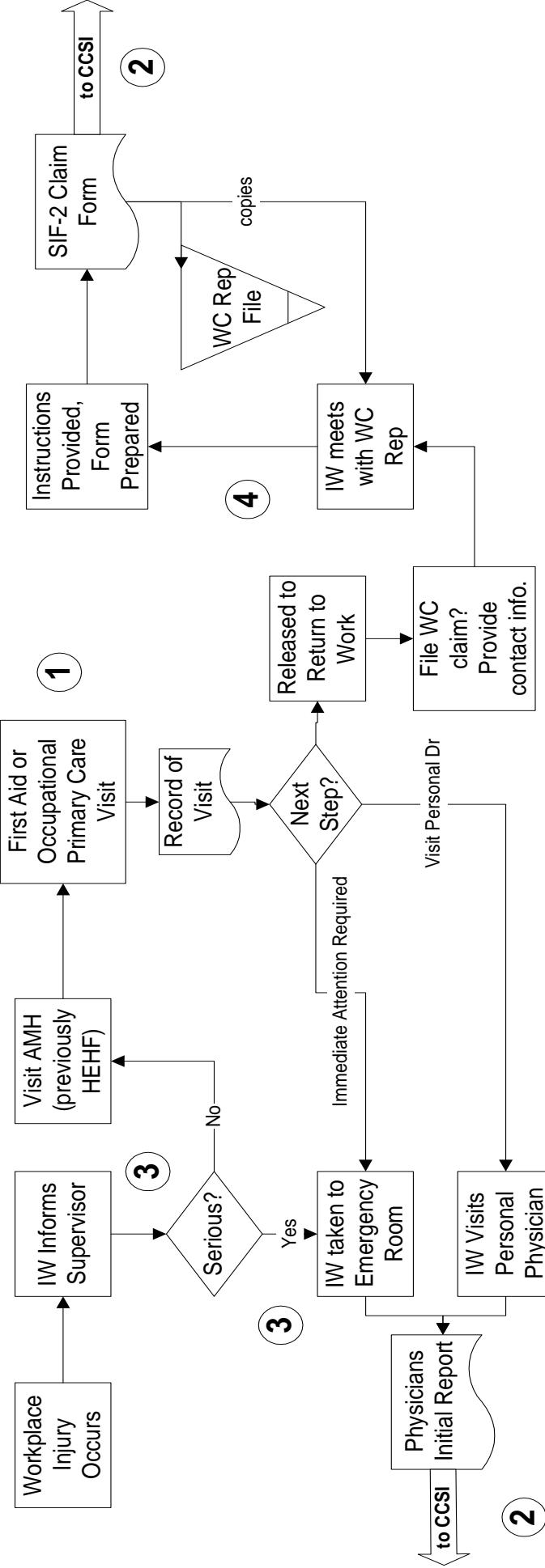


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Notes for Functional Organizational Structure Chart

The functional organization structure shows that there are many information flows and working relationships between the entities involved. However, there are other information flows not presented. For example, CCSI reports certain claim information to the Department of Labor for its administration of the EEOICP program. In addition, DOE and DOL work cooperatively regarding information sharing in the EEOICP program. Another example is that retired employees are shown as being linked to Fluor-Hanford. While this company does manage the retiree programs for most of the retired employees other companies are also involved.

Generic Workplace Injury Process



Notes for Generic Workplace Injury Process Flow Chart

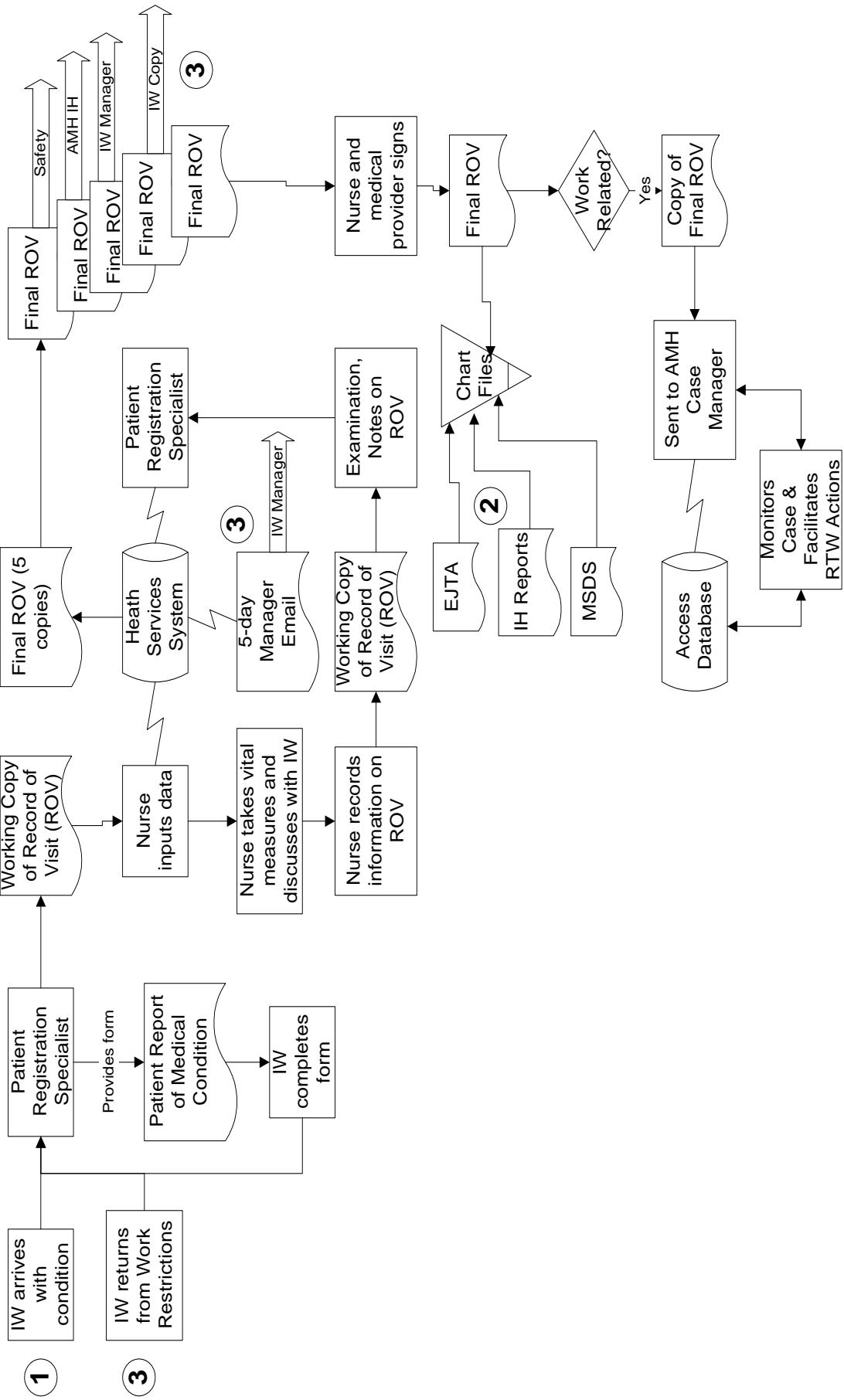
- ① The Advanced Med Hanford Patient Intake Process is more fully documented at flowchart A-6.
 - ② The CCSI Claims Management Process is more fully documented at flowcharts A-9 and A-10.

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- ③ For most employers (contractors) the supervisor will accompany the IW to AMH or, if necessary, the Emergency Room in a hospital. The notes following the chart presented on A-14 describes each contractor's process.
- ④ The typical Employer Representative Claims Management Process is more fully documented at flowchart A-14.

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Advanced Med-Hanford Patient Intake Process



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Notes for AMH Intake Process Flow Chart

- 1** As explained in Note (3) to the generic injury process flowchart, a representative of the employer typically accompanies the IW.
- 2** Recently, AMH began printing out the Employee Job Task Analysis (EJTA) for inclusion in the chart file. The company manager and industrial hygiene function prepares the EJTA, and it is maintained in the RMMS system. The IW, the manager or the safety representative typically brings in the MSDS when a visit occurs. AMH also has access to the MSDS system. The safety function contact may also be provided the MSDS regarding exposures and sometimes the IH reports will be included in the chart files.
- 3** The AMH provider sets a reassessment date on the ROV. This date is entered into the Health Services System (HSS). Five days prior to the reassessment date, the HSS generates automatic email messages to the IW's manager. This flow chart assumes that the IW reports to AMH on or before the reassessment due date.

Additional AMH Intake Process Information

IW presents themselves to a patient Registration Specialist (PRS). The PRS provides a Patient Report of Medical Condition form to complete. The first question on this form is whether the visit is due to a job related injury/illness. If so, information about the nature of the incident, the injury and body part affected, the date, time and location of the incident, and the supervisor's name is requested. The second part of the form addresses information about returning to work following an absence. The information requested includes the last day worked, surgery or hospitalization specifics, the AP's name, date of last AP visit and current medications. Whether the visit is for an initial injury or a return to work visit, the IW signs and dates this form. A nurse inputs this information into the Health Services System (HSS) and prepares the chart from discussions with the IW, the patient statement and taking of vital measures. A working copy of the Record of Visit (ROV) is used to manually record information as the visit and examination proceeds. This working copy is then used by a PRS to input into HSS. A final ROV is printed out, and two copies are provided to the IW (one for IW's manager and the other for the IW files), one copy is provided for the chart records and unless a safety function representative is present during the visit (in which case they would be provided a manual copy) a copy is electronically submitted to the safety representative. A copy of the ROV is also provided to the IH function within AMH. Recently, AMH began printing out the Employee Job Task Analysis (EJTA) for inclusion in the chart file. The safety function contact may also be provided the MSDS regarding exposures and sometimes the IH reports will be included in the chart files.

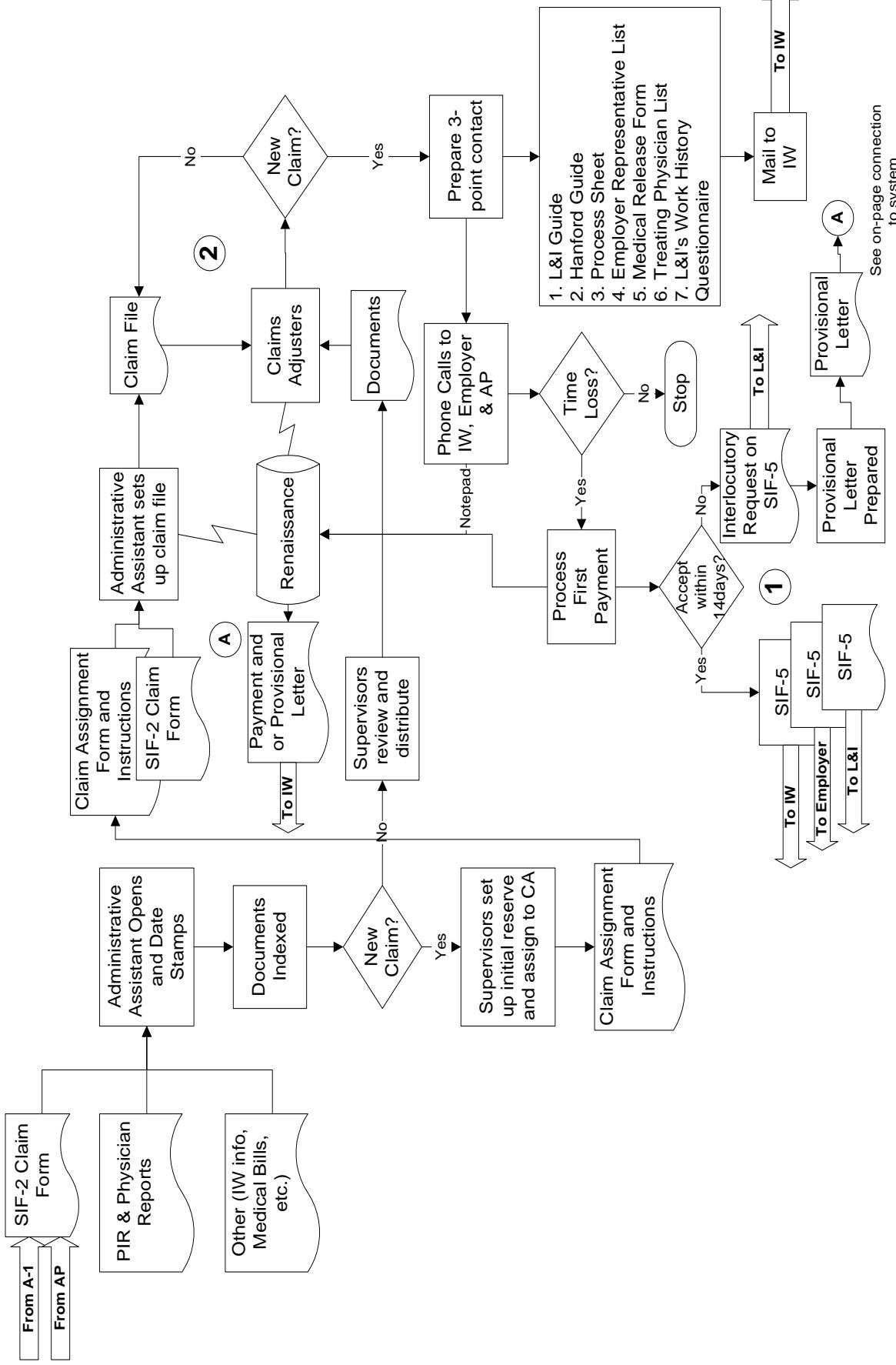
During the visit an employer representative contact list is provided to the nurse to give to the IW if the patient advises that the incident was a work-related injury/illness. Once the chart file documentation of the ROV is complete, it is signed by the attending nurse and the medical provider (either an MD or a Physicians Assistant). If work-related, a copy will go to the AMH case manager to enter into an Access database to track case progress and facilitate return to work actions.

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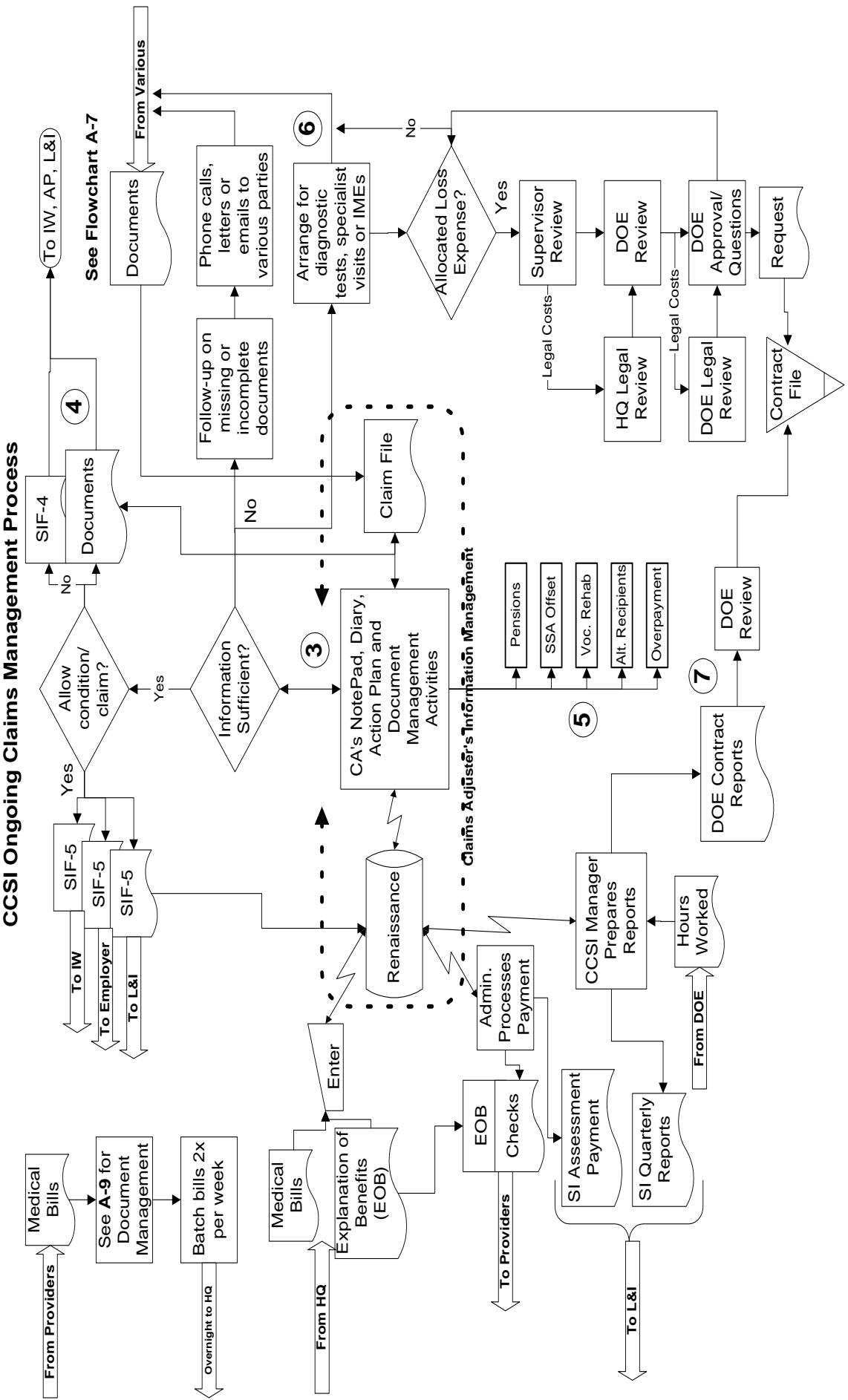
If the injury/illness involves work restrictions, a follow-up visit and monitoring is performed. Using HSS daily notices are sent to managers via email beginning one week prior to the scheduled return date regarding availability of the position given the work restriction or full release. The follow-up visits result in either a continued restriction, a modified (changed) restriction or a removed restriction. There can be several reiterations of this process depending upon the outcomes of any specific follow-up visit.

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CCSI Initial Claims and Document Management Process



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Notes for CCSI Initial Claims and Document Management and Ongoing Claims Management Process Flow Charts:

- ① This Flowchart presents a highly summarized process regarding the interaction between claims adjudication decisions, the filing of interlocutory requests for time extensions and the filing of required L&I forms. The decision process is much more involved than presented. This note provides additional information. If a claim involves time loss benefits, CCSI sends a complete and accurate SIF-5 (Self-Insurer's Report on Occupational Injury or Disease) and a SIF-5A (Time Loss Calculation Rate Notice) to the IW at the same time that the first time-loss (TL) payment is due/paid (14 days from receipt of claim). Within 5 working days of the first TL payment, copies of these forms along with a copy of the SIF-2 are sent to L&I. L&I will allow the claim unless L&I has received a request for interlocutory order or a denial. The interlocutory order places a claim in provisional status while CCSI investigates the validity of the claim. In order to make its determination, L&I requires copies of the forms discussed above and all medical and other pertinent information and a reasonable explanation why an investigation is needed. If a claim does not involve TL (Medical Only or MO), CCSI has 60 days, within which the request for the interlocutory order can be made. If L&I agrees, any TL benefit is placed in provisional status. Medical treatment services are not payable unless the claim is allowed. If L&I does not agree, it will issue an allowance order, which means that TL benefits are not provisional and that medical services are payable.
- ② The interaction between the claim file, the Renaissance system (REN) and the Claim Adjuster's use of them is more fully described in the ongoing claim management process flowchart at A-10.
- ③ This grouping of manual files, the Renaissance system, used by CCSI in its claim management activities, and the Claim Adjuster's (CA) interaction with both the management information system and documents contained in the manual claim file depicts an ongoing reiterative process. These functions, especially the claims adjudication process, are more of a case management model than a transactional flow model. As such, a work flow diagram is limited in its ability to document the decision process involved in managing claims. The process of creating an action plan, establishing diary review dates, reviewing medical reports and vocational rehabilitation reports is a reiterative process, with each successive claim management decision building upon past decisions and new information.
- ④ When requesting claim denial from L&I, CCSI sends the SIF-4 (the Self-Insured Employer's Notice of Denial of a Claim) to the IW, the AP and L&I within 60 days of receipt of claim. In addition to the SIF-4, CCSI sends all medical and other pertinent information supporting the denial. L&I can agree, disagree or find that insufficient information was provided to make a decision.
- ⑤ There are several claims management activities that are infrequent and have a specific process that is used for the specific activity. When applicable, these management activities occur. In order to keep the workflow documentation from being overly complex, we have simply noted these activities on the flowchart and have provided brief descriptions of the related processes as follows:

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PENSIONS: Once legal/protest issues, vocational issues and medical issues are all resolved in a way that indicates that a pension benefit is appropriate, CCSI submits a SIF -5 with a cover letter and the ability to work assessment from a vocational rehabilitation consultant to request (a referral) that L&I assume the pension claim. L&I determines whether the pension claim is accepted and may require additional information before a final O&N is produced.

SOCIAL SECURITY BENEFIT OFFSETS: DOE, under the state's self-insured program, is allowed to offset Time-Loss payments with benefits the injured worker receives from the Social Security Administration (SSA). The offset can begin one month after SSA benefits begin. If a CA becomes aware of the potential for SSA benefit offset, a diary note is made and CCSI submits a written request to L&I, via fax or mail, requesting a search on whether the claimant is receiving SSDI benefits and if there is any offset to time loss benefits. If L&I confirms receipt of SSDI benefits, they determine if any offset is taken and will issue an O&N, which outlines the calculations, new monthly time loss rate, and effective date, as well as any overpayments resulting from the receipt of SSDI. Upon receipt of an O&N from L&I, the CA is required to adjust the time loss rate with bi-weekly deductions for any overpayment in accordance with the O&N (usually deductions are taken at 1/6th per month of the total amount of overpayment, unless the overpayment is a high dollar amount). The new TTD rate, less deduction for overpayment, is re-entered into the Renaissance auto-payment system until the overpayment is recouped. At that time, the adjuster is required to again re-enter TTD into the auto-payment system according to the time loss rate provided in the O&N.

VOCATIONAL REHABILITATION: Claims Adjusters may select vocational rehabilitation (VR) counselors, when deemed necessary, based upon an understanding of well-performing providers. Vocational rehabilitation counselors meet state requirements. In addition, the use of a vocational rehabilitation counselor is considered an "Allocated Loss Expense" under the DOE contract, which requires DOE approval before the service is provided. Claims Adjusters monitor the work of providers in individual cases by reviewing the VR reports provided in relation to the diary notes for that case.

ALTERNATIVE RECIPIENTS: The SIF-2 contains information about dependent children and the name and address of the children's legal guardian. This information is input into REN in the claims initiation process. CAs may review and change this information using the REN system and can create, review, update and delete any alternative recipients. The number of dependents affects the benefit amount, while alternative recipients determines how the benefit is to be paid to various possible payees.

OVERPAYMENTS: For various reasons, the CA may determine that a claim overpayment has occurred. The dairy or notepad system is used to document denial of dates of time-loss benefits previously paid. This procedure can be used to assess an overpayment for all or part of a previously paid time loss (TL) or loss of earning power (LEP) period. The CA updates the notepad regarding denial dates that should not have been paid, whether the benefit payment will be adjusted from future benefit payments, or whether the IW will repay the amount. Excel is used to compute the overpayment, a letter to the IW is prepared, and when the amount due from the IW is received, the amount is entered into the Payment History in REN.

Overpayments due to recalculation of the compensation rate or for other reasons, such as permanent partial disability (PPD) are managed the same way using the notepad function and recording receipts in the payment history in REM. Excel is used when the CA needs to recalculate a previously paid period due to a change in the compensation rate, i.e., a change in the number of dependents, alternate recipients, wages or liens, etc. This procedure recalculates the payables and issues payments to the worker, the alternate recipients and/or lien recipients for additional time-loss or loss of earning power benefits. If both the wages and dependents have

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been updated since the payment(s) were made, the CA uses both changes in the recalculation process. This process is also used to pay time-loss or LEP benefits that have been withheld from the original payable(s) created through REN due to liens. Lien notices are typically received when a claim is no longer in provisional status and CCSI initiates payments according to the lien notice.

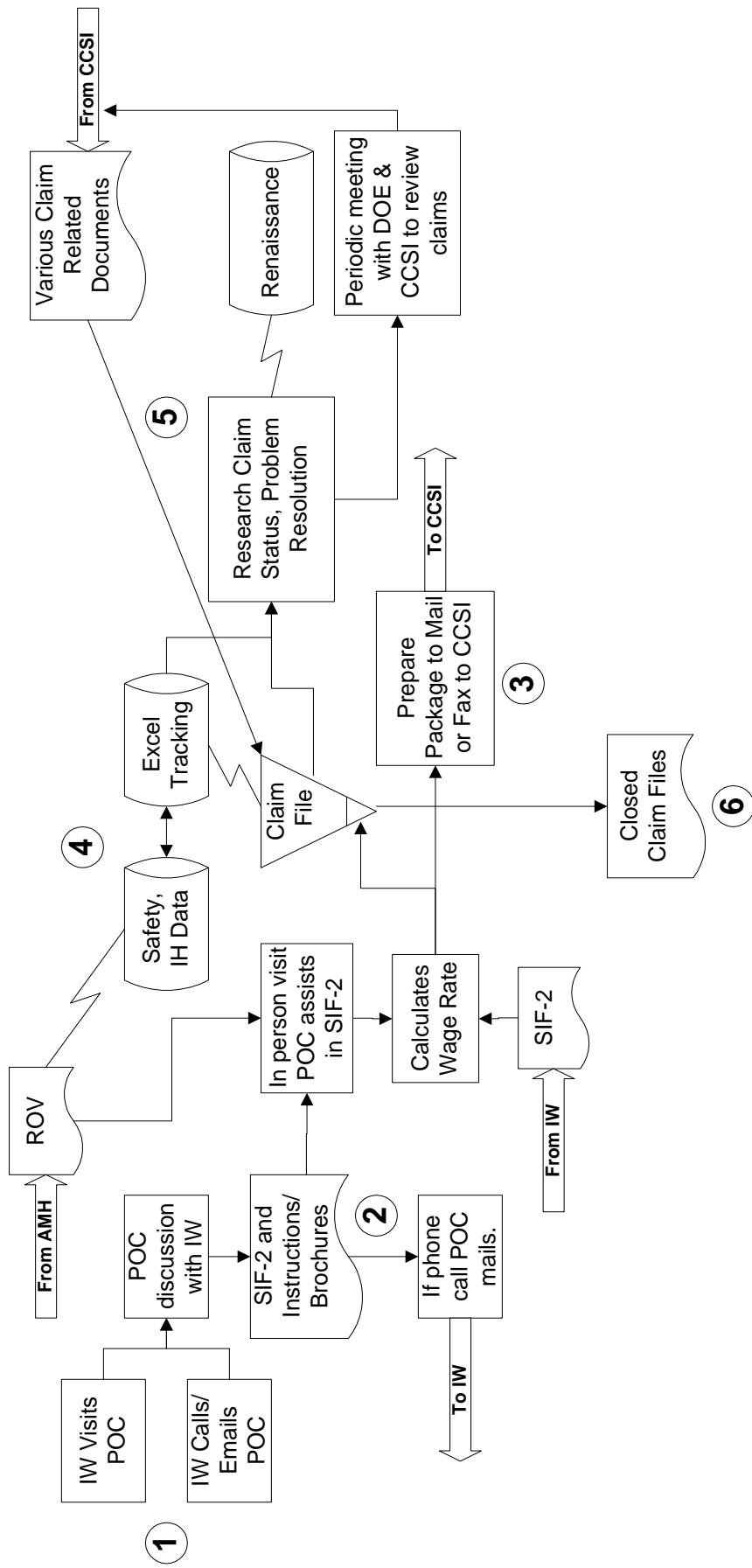
A CA can use REN to review the assessment history for a claim, a claimant, alternate recipients and lien recipients. A CA can also review details of specific payments and deductions credited toward each overpayment. Due to the small number of overpayments at any given time, an accounts receivable system is not utilized as the combination of the notepad and payment history functions in REN is deemed to be sufficient to monitor amounts due from overpayments.

6 There are varying reasons to request an Independent Medical Examination. Some reasons include, but are not limited to: 1) at the treating physician's request, 2) to obtain a Permanent Partial Disability rating, 3) to obtain concurrence on diagnosis and/or treatment plans and 4) to challenge a diagnosis. CCSI has in-house medical support capabilities, which the CA may access when it is considered desirable. There are times when the CA may wish to request an occupational nurse opinion but more often CAs consult with the nurse about needing clarification on medical issues.

7 This periodic reporting is used in individual meetings with the Employer Representatives, CCSI's CAs and Managers and DOE Contractor Industrial Relations staff. These meetings are held frequently (at least once per month) to review the status of individual claims and other emerging issues.

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Employer Representative WC Management Process



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Notes for Employer Representative Process Flow Chart

NOTE: This chart is a general depiction of the employer representatives' (referred to as the POC, Point of Contact below) activities related to their management of the workers' compensation program. It shows activities that are generally performed by all contractors. Specific information for each contractor interviewed is provided immediately following these notes.

- ① Refer to the Generic Workplace Injury Process flowchart at **A-4** and the AMH Patient Intake Process flowchart at **A-6** for activities that occur prior to the employer representatives' activities and that initiate this process.
- ② Each contractor has information that is provided to the injured worker. The nature of the information ranges from one page sheets of instructions on completing the SIF-2, where to send it, and time keeping instructions, to a multi-page "booklet" describing various aspects of the workers' compensation system.
- ③ In addition to the SIF-2 and Wage calculation documentation, this package may include a copy of the incident report (if one was prepared) and the EJTA, prepared by the safety or industrial hygiene functions. If applicable, the ROV received from AMH is included in the package sent to CCSI. The POC may forward on other information, such as a Physician's Initial Report if it was received by the POC.
- ④ Communication and information exchange between the workers' compensation activities and the safety or IH functions varies by contractors. Most use a combination of manual files and Excel tracking for tracking claims and a database for safety, OSHA, incident reporting, etc. Most will jointly use the ROV from AMH, if applicable, for information related to each need. This chart simply reflects that there is information sharing between these systems/functions.
- ⑤ The interaction between the POC, their manual claim files, their tracking systems (usually Excel), receipt of documents from, and sending documents to CCSI and the online review and inquiry of CCSI's Renaissance system is a reiterative process until the claim is closed.
- ⑥ Closed claim files may be segregated from open claim files. In addition, closed claim files for retired or terminated employees may be forwarded to DOE archives.

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Pacific Northwest National Laboratory (PNNL)

When an injury occurs, the IW, his manager or supervisor contacts the POC to determine whether the injury was incurred while the IW was working on government or private work. If the IW was working on government work, the claim is filed under the DOE SI program. If the IW was working on private work, the claim is filed under a state fund account. When the case is determined to be related to private work, the POC advises the IW to file a state fund accident report with their AP and sends the IW a document entitled "A Glance at Workers Compensation – Battelle Employees". The POC completes the "Employer Section" of the state fund accident form when received from L&I and submits it to L&I.

If the claim is related to government work, the POC sends the SIF-2 claim form to the DOE SI program to the IW and attaches a document entitled "A Glance at Workers Compensation – Battelle Employees" at the time they contact the POC to report the claim. POC may receive a claim form in the mail, but will more likely assist in its preparation during an IW visit. The IW retains one copy of the claim form. The information is input into an Excel spreadsheet (dates sent, returned etc.) The wage and other employer information is prepared and sent to CCSI. If time loss is involved under either the State Fund or DOE SI system, the POC calculates the wage information and the documentation is filed manually by employee name under the appropriate claim system.

After a claim is filed, the POC tracks the status of each claim in an Excel spreadsheet. On rare occasions, the IW will go directly to their AP or the ER, and file for benefits under the incorrect system. In these cases, the POC works with CCSI and the state to ensure that the claim is filed under the correct program.

PNNL Worker Safety and Health receives notification of all injuries and illnesses. A physical case file is set up in the OSHA Record Keeping Office, and the case is also entered into a database for OSHA record keeping and tracking purposes. The cases are assigned at that time to a Field Safety and Health representative, who carries out a case investigation. Upon request, the case investigation information is provided to the WC claims manager in a report format.

If an IW has a problem with some benefit approval aspect of the claim, the POC may be contacted. The POC first looks to see if claim, or treatment authorization request has been approved/allowed. This may require a call to the CA at CCSI or L&I, depending on the program under which the claim was filed. Occasionally, the CA is in process of obtaining necessary documentation to make a determination. If there is a problem with the receipt of documentation, the POC may advise the IW to contact the party (i.e., the AP that is responsible for supplying the documentation) and request that it be supplied to the CA.

The POC meets with CCSI approximately every three weeks to discuss current status of open cases. Once the claim is closed, the POC receives a letter from CCSI. This information is entered into the tracking spreadsheet, unless there is a protest or appeal. If a claim is reopened they are informed, and CCSI represents them in these processes/procedures.

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Fluor Hanford

The POC sends out an SIF-2 (claim form) when notification of an IW occurs. This notification may come through the IW, AMH, management, or someone from the safety organization. Issued claim numbers are tracked on an Excel spreadsheet. Along with the SIF-2, the POC attaches an explanation of "What to Expect" and a cover letter. POC may receive a claim form in the mail, but will more likely assist in its preparation during an IW visit. The IW retains one copy of the claim form. The wage and other employer information is prepared and sent into CCSI along with the SIF-2, event report (if available), and Employee Job Task Analysis (EJTA). If the claim involves time loss, the manager is notified about how to properly complete the time card/ time tracking function. POC rarely has to follow-up with APs to get the PIR returned to CCSI, as CCSI does this follow-up function. In summary, a significant amount of information may be provided to CCSI, depending on the nature of the claim.

Once this initial information is sent into CCSI, the POC monitors the claim through use of the Renaissance notepad and ongoing communication with the CA. Meetings are held with CCSI and POC on an as-needed basis. The POC is available to the IW at anytime to discuss issues and/or problems about the process. For example, the various involved parties may misinterpret email or phone messages. Also, staff may not be clear about the difference between the safety reporting system and the workers' compensation process.

Once POC receives the "accept" or "deny" letter from CCSI, information is entered into the tracking spreadsheet. Even though there may be a denial, the POC may need to monitor the time coding by the IW for other benefit plan purposes.

Advanced Med Hanford

The WC manager can access individual information from Renaissance (the CCSI extranet) but for only claims involving their company's employees. The manager works closely with the "Single Point of Contact" (SPC) for safety and OSHA reporting. They receive a record of visit (ROV) from the clinic. This ROV goes to the safety department, with a copy to the manager and a copy to the IW. The SPC reports incidents on a form or log to DOE.

The IW's supervisor might call ahead to alert the clinic of an impending visit. The medical provider makes a determination of condition based on the examination during the patient visit. The Patient Registration Specialist requests and obtains the necessary information and sends the information using an online (PDF) form in their intranet to the SPC. This document can be saved as a Word document so that information about the date, time, RTW decisions and personal information regarding the ROV can be input or read. The form has many purposes and the workers' compensation information is only one aspect of the form. Part of the information on this form is tracked using an Excel spreadsheet. Part of this information is forwarded to the company's Industrial Hygiene (IH) function and might investigate a site visit. Copies of this multiple-use form go to an epidemiologist, the case manager (who would reconcile the SPC information to the ROV registration forms), the Industrial Hygienist, the Medical Director and the company's management team.

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CH2M Hill Hanford Group, Inc.

The Safety Department of the company has a Safety Professional ("Employee Health Advocate") on call 24/7. When an IW goes to first aid (AMH clinic visit) or an emergency room visit, the notifications required by company procedure are made, including notification of the On-call Safety Professional. Any time there is off-site work related medical treatment the On-call Safety Professional responds, and notifies the POC. For on-site work related medical treatment, AMH provides the IW with the POC name and phone number for assistance after the visit/exam at AMH, and notifies the POC by providing an ROV electronically.

From the ROV, the POC can follow-up. Even if the IW does not want to file a claim, an incident report (prepared and signed by the manager and the employee) must be provided to the safety function. After the worker files a claim, the POC may assist the worker by contacting the off-site medical caregiver with the claim number and put them in contact with CCSI for claim activities. CH2M Hill also maintains a company website for employees to initiate a claim, find workers compensation information, and electronically request a claim.

The IW would normally come into the POC office to fill out the claim forms. If needed, they would be offered help in understanding the form. Once the forms are completed, the POC sends them to CCSI along with the incident report. The POC maintains hard copy files and uses a checklist of all required information to ensure that all required information has been obtained and sent to CCSI. The initial information to CCSI usually includes the ROV, the EITA and the incident report. POC uses the checklist to document if information was obtained, the date received and the date sent to CCSI. The wage and other employer information is prepared and sent into CCSI. The POC provides the detailed wage information in a standard format from the site payroll department, to CCSI. POC has access to their portion of CCSI's Renaissance system to research claim status on-line, and may use data sorts to determine if payroll, benefits, or employment information is due from the company to CCSI.

POC provides the IW and their manager with information to properly complete the time card for any time away due to the claim. POC provides time away authorizations for company benefits related to Workers Compensation Claims, and it assists managers and employees regarding the company benefits. POC also audits the use of the company benefits related to Workers Compensation claims to verify that reporting in the time reporting system matches up approved absences (PT, medical visits, etc.). POC can use CCSI's Renaissance system to see if PT, exams, etc. have been authorized. If actual time taken does not match approved time, an email is sent to the employee and their manager.

The claim status is tracked until closure. On some occasions, POC may provide records to or request records from, CCSI involving protests, appeals and litigation. Some of the records involve industrial hygiene reports, dosimeter reports or readings from instruments that detect chemicals in tank vapors. POC acts as liaison between CCSI and the company for claim information.

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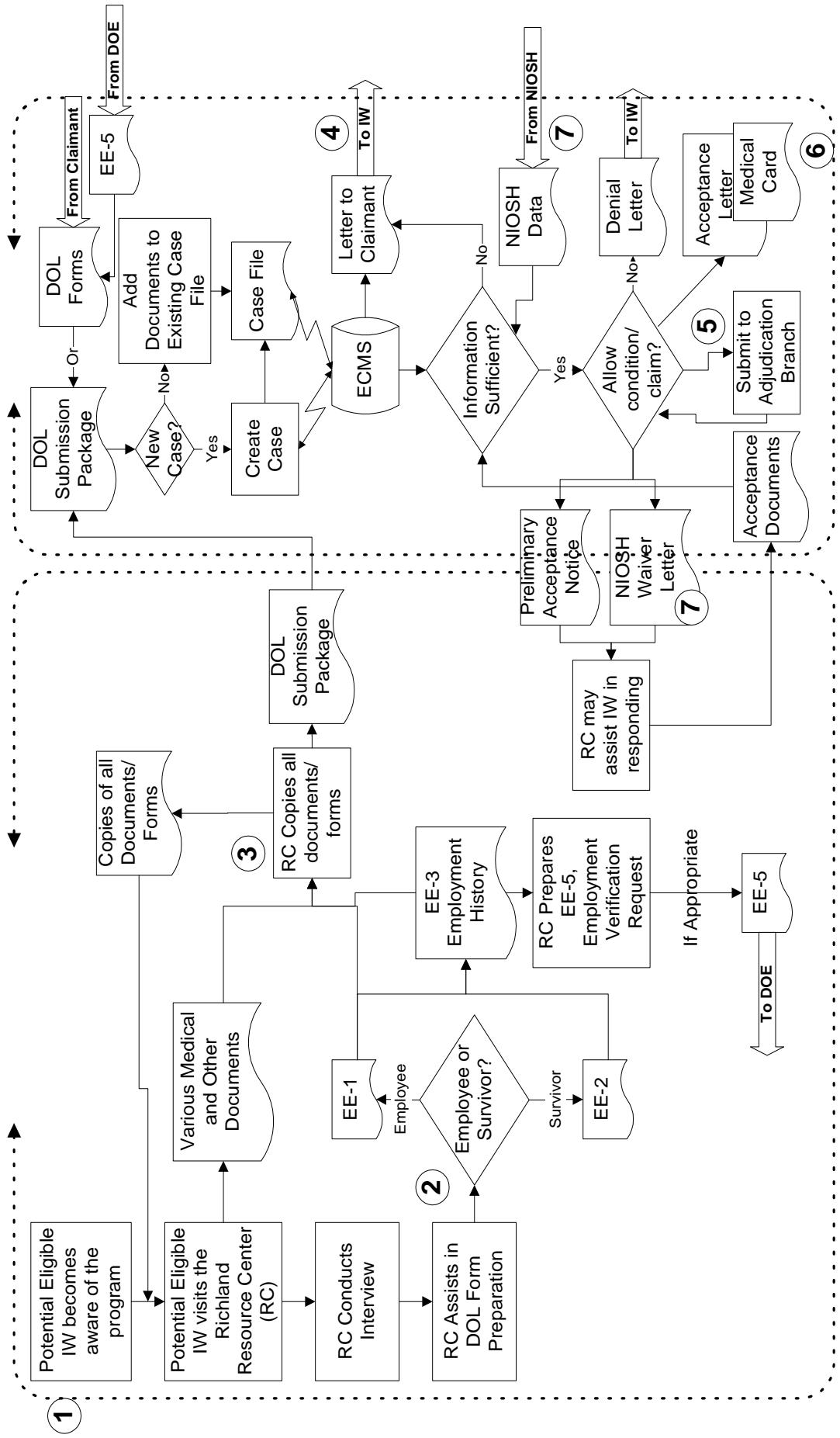
Washington Closure Hanford LLC

The safety representative or the IW supervisor (who escorted them to the medical caregiver, either AMH or off-site) calls the POC and sets up a time to administer the claim form paperwork. If the IW visited the ER or AP directly, POC calls them and provides the claim number. The POC mails or faxes the claim form to CCSI. POC uses an Injury Database and also maintains a hard copy file that includes claim forms and incident reports. The incident report is based on an investigation by a safety representative, the employee and others. This incident report is also used for OSHA reporting.

The POC reviews CCSI's Renaissance system and will call the claim representative to follow-up on progress and to help obtain documents (especially if the IW is absent from work). POC will also assist the IW in locating a medical specialist for examinations or testing. The letter closing the claim is filed in the hard copy file. If an employee terminates employment, retires or a company contract is ended, the file goes to DOE archives.

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EEOICP Resource Center and U.S. Department of Labor Claims Management Process



Hanford Energy Employees Compensation Resource Center

DOL EEOICP Program

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Notes for Energy Employees Occupational Illness Program (EOICP) Process Flow Chart

- 1 This process flowchart does not document any outreach program to current or former Hanford workers. It starts with individuals presenting themselves to the Hanford Energy Employees Compensation Resource Center (RC). The RC is contracted by the US Department of Labor (DOL) to assist individuals in initiating the EOICP claim process. Certain individuals may file appropriate forms directly with the Regional Office in Seattle, in which case the potential beneficiary would go through a similar process regarding form completion.
- 2 The EE-1 form for employees and the EE-2 form for survivors of deceased employees are similar in many respects. The EE-2 requests information about potential survivors, date of death, etc. Both forms require an indication of the date of diagnosis for cancer, beryllium sensitivity, chronic beryllium disease, chronic silicosis or other conditions due to exposure to toxic substances. It also asks if a claim application under the Radiation Exposure Compensation Act (RECA) has been filed.
- 3 The accumulation of completed forms, other documentation, and the overnight mail to the Seattle DOL District Office may involve several reiterations. RC staff has been instructed to not screen documents for their relevancy, but to send any and all information provided by employees or survivors to DOL. In addition to medical and work history information, the submission package might include death certificates, marriage certificates and birth certificates of dependent children or beneficiaries to document the relationship to the Injured Worker. DOL might send a letter to these individuals asking for this information if not initially provided, and the individuals may visit the RC to have them assist in the DOL requests. Once the RC receives notice that documents have been received in the Regional Office, the copies are destroyed.
- 4 The purpose of the first letter is to inform the individual that DOL has received his/her information. DOL may also send other correspondence requesting information necessary to adjudicate the claim.
- 5 Once documentation is complete and an adjudication recommendation can be made, information is sent to the DOL Adjudication Branch, which can send the claim back to the Seattle District Office for further investigation, accept the claim or deny the claim. If it is determined the claim should be accepted, the DOL District Office will issue a Recommended Decision (RD). This lays out the basis for the acceptance and a discussion of the benefits awarded. A copy of this decision is given to the claimant with appeal rights. The case is then given to the Final Adjudication Branch (FAB) for review and Final Decision (FD). If the claimant does not elect to waive the appeal rights an FD will not be issued for at least 60 days. If they do elect to waive their rights, it may be issued sooner. Once an FD is made the claimant will be given another set of appeal rights to exercise if he disagrees with the determination.

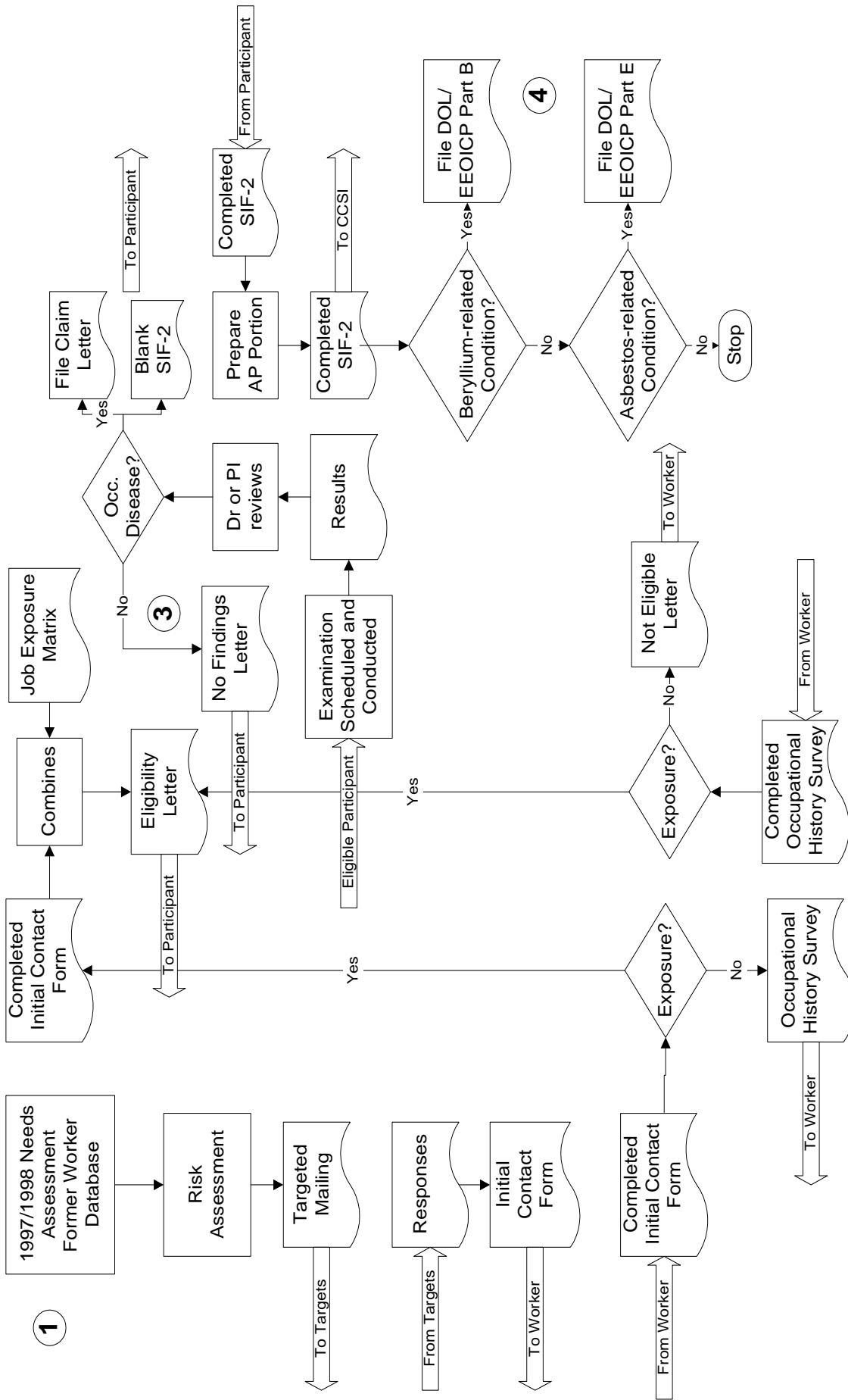
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- ⑥ Accepted participants in the program receive a medical card that allows the medical provider to submit the appropriate billings. In a few cases individuals who have been denied a lump-sum compensation (due to a diagnosis of only beryllium sensitivity and not chronic beryllium disease under part B or if the individual was not able to be rated for impairment under Part E) can receive a medical card for ongoing medical surveillance/treatment.

- ⑦ Under Part B many claims go to NIOSH for dose reconstruction once DOL has verified covered employment and a covered condition. If the case goes to NIOSH, it may be quite some time before DOL receives the dose reconstruction. There are cases that have been returned within a matter of months and others in a matter of years. There are a great many variables that impact this process. There are other cases that do not go to NIOSH, depending on the claimed condition. Under Part E many claims will not go to NIOSH, as the radiogenic component is not the toxic exposure claimed, or that issue has already been determined.

University of Washington Former Hanford Worker Monitoring Program

2



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Notes for University of Washington Former Hanford Workers Monitoring Program Process Flow Chart

- 1 This Process Flow Chart begins with a database of former Hanford workers that has been developed over many years (starting in 1997 and 1998). The University of Washington, under a grant from the US Department of Energy, has undertaken a program of monitoring the health of former Hanford workers. As a part of this project, an identification of former workers, their likely exposures from certain materials present at certain work locations, and periods of time were accumulated. Data was obtained from the Central Epidemiological Data Repository (CEDR), the Flow Gemini system, used by the Hanford Environmental Health Foundation for scheduling and medical examination, the Radiation Exposure Monitoring (REMS) maintained by DOE-Headquarters, OHH88, for employment history data and the Radiological Exposure System (REX) maintained by the Pacific Northwest National Laboratory. This database has been updated from other sources since 1998.
- 2 This chart does not reflect the activities of another UW program related to waste management activities at Hanford. The UW received a grant to provide independent examinations of "Tank Farm" workers and assist an advisory committee in oversight of "Tank Farm" health issues. Under this grant UW provides for examinations at either the Bi-state Occupational Health Clinic, Kennewick General Hospital or at Harborview in Seattle. This program uses many different diagnostic tests and background information. Based on the test results, this program will make one of the following three determinations. An occupational illness or disease has occurred, in which case, a workers' compensation claim should be filed with CCSI or, if applicable, the DOL/EEOICP. Some abnormalities exist, which required additional testing (the UW grant pays for this additional testing). There are no positive findings, and the participant is instructed to visit their attending physician to determine if other causes for the condition exist.
- 3 If there are no findings to indicate work-relatedness, and job history indicates no exposure to asbestos and/or beryllium, the letter states that the participant does not need any follow-up examinations. However, if job history indicates potential exposure, a follow-up examination in three years is recommended (due to latency of disease).
- 4 Refer to previous EEOICP/ DOL flowchart for how these claims are filed and administered.

Appendix B: Summary of Claim File Review

		COUNT		COUNT	AVERAGE
	YES	NO	OTHER	OVERALL CLAIMS ASSESSMENT	
TOTAL FILES REVIEWED	48			1 (EXCELLENT) 2 (GOOD) 3 (FAIR) 4 (POOR)	
KEY ATTRIBUTES					
				1. CONTACT CONTROL	
TTD/TPD PAYMENTS					
First Payment Timely	6	1		Employee	44 1.39
Continuous payments timely	6	1-N/A		Physicians/vendors	43 2.28
TTD/TPD calculation correct	6			Supervisor	44 2.11
Correct number of days paid	6			Phone Call Turnaround	32 2.06
				2. MEDICAL CONTROL	
BILL PAYMENTS				Action Plan	46 2.13
All bills paid per the statute of 60 days of receipt of final billing	30	8	(8-N/A, 1-Unknown)	Timely Medical Reports	45 2.29
60-day Bill Turnaround number current	203			Diaries	46 2.52
Out of number of total bills	238			Medical Case Management Timely	45 2.51
Percentage Timely	85.29%			Investigation – Medical	44 2.36
				IMEs appropriate	35 2.26
				Investigation – Sub-Rosa	1 2.00
EARLY INTERVENTION PROGRAM	10	1	(1Unknown)	60-day Bill Turnaround, number current*	38 5.34*
Return to Light Duty				Out of number of total bills*	38 6.26*
RCW 51.32.090 correctly applied				Proactive vs. Reactive Adjudication	46 2.43
				*- Not a rating, average of bills paid per file	
DENIED CLAIMS	15			3. RETURN TO WORK	
Denial requested				Early Intervention	6 2.67
If yes, SIF-4 completed within 60 days of notice of claim or Expiration of Interlocutory Order	8	7		Vocational Needs Identified Timely	1 3.00
All records submitted to the Dept of L&I with the SIF-4	15			Cost Effective	4 2.50
Adequate documentation for denial	10	5		Employability Assessment Report Timely	1 4.00

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				COUNT		COUNT		COUNT		AVERAGE		
		YES	NO	OTHER	4. LITIGATION							
REOPENED CLAIMS					Timely Identified						3	3.00
Re-Opening Application forwarded to L&I timely		2			File Preparation						3	3.00
Provisional TTD due		1	1		Communication						2	3.00
If yes, paid timely		1										
RESERVES					5. CLAIM CLOSURE							
Initial incurred adequate		46		(1-other)	Open/Close Time Appropriate						41	2.37
Reserve changes adequate		13	2		Submitted Accurately / Benefits Paid						37	2.16
Reserve changes timely		13	3		Reported Correctly						27	2.15
					SIF-5s correct						19	2.16
					All bills paid						35	2.06
DIARY					6. SUPERVISION							
On Diary		44	1		20 days						46	2.41
If no, # Days Off Diary					Diary Review						46	2.39
Action Appropriate		41	3		Communication						46	2.37
Initial Diary Appropriate		20	24		Training						46	
Intervening Diaries Appropriate		28	17									
Current Diary Appropriate		39		(7-Unknown)	7. RESERVES							
Red Flags Reviewed		39	2		Initial Reserve						46	1.98
Appropriate File Doc		36	5		Total Incurred						46	2.00
Subrogation Potential Reviewed		41										
					8. CLIENT RELATIONS						45	2.00
					9 ORDER & NOTICES							
					Timely response						19	2.11
					Adequate Documentation						22	2.41
					Defense Attorney Assigned Appropriately						4	2.50
					Communication w/ Plaintiff						5	2.20
					10. OVERALL COST EFFECTIVENESS						46	2.43

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Overall Rating	Legal or Regulatory Requirement	Sound Business Practice	
		Comments	Observation
2	No comments.		Delay in diaries and medical management did not significantly affect outcome.
2	4 of 5 bills paid within 60 days.		Otherwise, claim handled well.
2	19 of 20 bills paid within 60 days.		Medical Case management would be improved if they did an IME prior to closing order due to prior injury, due to many pain symptoms. Prior injury noted in PIR but records not requested by CA. Otherwise handled well.
3	No comments.		Claim closed 10 months after reported. No PIR in file when SIF-5 was prepared. 90 days for IW to find AP. Then another 30 days to send audiogram to AMH for validation. 60 days later, a SIF-5 Final sent. This claim could have been closed more quickly.
1	No comments.		Claim handled well.
2	SIF-4 was submitted 2 months late and no Interlocutory Order requested.		Claim transferred to supervisor, but there was no follow through. Assigned to CA 4 months after receipt and 2 months after transfer to supervisor. Since records were received timely, claim could have been denied much earlier if diary and reviews were timely.
2	SIF-4 60 days late, no interlocutory O&N requested.		IW was unresponsive, which caused delay. Other than legal requirements, claim handled well.
2	3 of 5 bills paid within 60 days.		Most calls made timely and appropriate, but a return call to AP requesting Physical Therapy was not made. 14 days between receipt of SIF-2 and initial CA review is longer than sound business practice.
2	Request for Interlocutory order was late.		The late request for Interlocutory order did not cause SIF-4 to be late. Otherwise handled well.
2	One bill was not paid within 60 days and another could not be determined. As such, either 1 of 2 or 2 of 2 bills were not paid within 60 days.		The difference in diagnostic tests was not pursued. Otherwise handled well. No date stamp on one bill, so conclusion of timeliness cannot be made. We found that date stamps are used on a consistent basis, so no recommendation needed.
4	SIF-4 was approximately 5 months late. Inadequate documentation for denial.		There was an approximate 4-month gap in diary management causing a significant delay. During this period a call by the IW was not returned, and the IW followed up by both a letter and an email. A consult with a specialist was approved and reaffirmed 4 months later via email. Within 4 days the approval was withdrawn and the SIF-4 was sent. There was no notice or explanation provided to the IW regarding the change in decision or the SIF-4 filing. IW was provided conflicting information, and the file documentation does not appear to adequately support the denial.
Claim not rated, as HL runoff does not require claims management activities.			
Overall			

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Rating	Legal or Regulatory Requirement	Sound Business Practice
2	No comments.	Issue that AP did not have Employee Job Task Analysis (EJTA) and that Hanford Environmental Health Foundation (HEHF) may have been overriding AP's release for full duty. CA did not address restricted duty release after AP became involved, and should have. Otherwise handled well.
3	Claim not rated, as HL runoff does not require claims management activities	Supervision of a new employee could have been better. This contributed to medical control issues, specifically management of reports, and diaries were not adequately handled.
4	20 of 23 bills paid within 60 days. No Employability Assessment Report (EAR) found in file.	Action plan not followed through on a timely basis. No diary reviews noted in file. Large gaps between dates of action in diary, resulting in delays on acting on medical reports. Request for segregation was not initially documented well. AP should have been contacted to address the "more probable than not basis". No action taken in five months to reschedule surgery. Had surgery been rescheduled in a more timely basis claim could have been closed earlier, thereby reducing employer's liability. Pro-active adjudication practices were not utilized.
2	2 of 3 bills paid within 60 days. No Interlocutory Order requested. SIF-4 sent more than 90 after receipt of claim.	Otherwise handled well.
2	8 of 10 bills paid within 60 days.	Given that compensability was questionable for a time, late payment of 2 bills are not considered significant.
2	No comments.	No comments.
3	17 of 20 bills paid within 60 days. Incorrect filing of SIF - 5 Initial. Temporary Total Disability (TTD) calculation poorly documented.	Claim took too long to close. Medical management should have addressed curative treatment but did not. Supervisor should have reviewed claim because it was a TTD claim.
3	No comments.	Diaries were not timely. Consequently medical information was not reviewed timely and submission for denial was late. Several medical documents were in file but were not acted upon. Timely processing of denial improves accuracy of reporting employer's liability.
2	No comments.	AP contact for reports was 45 days after claim was received. However claim was closed within acceptable timeframe. Otherwise handled well.
3	No comments.	Claim closing was delayed due to diary and medical control issues. Medical status was not requested until about 60 days after claim was received and medical status was not reviewed until 5 ½ months after claim was received.
1	No comments.	Simple denial of claim was handled appropriately.
Overall		

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Rating	Legal or Regulatory Requirement	Sound Business Practice
2	No comments.	<p>Claim was open for a year but reasons were adequately explained in file. Employer asked for an investigation, but there is no record that the results were reported to employer. Otherwise handled well.</p> <p>(NOTE: The following comments are significantly abbreviated due to IW-specific comments that are not included for confidentiality reasons.)</p> <p>First recorded diary review was 60 days after initial review. At least two notes indicated needed medical reports when they had been in the file for 30 days or more. Lack of diary dates are related to lack of review of medical reports on a timely basis. CA asked IW to contact AP for their office notes, instead of direct contact with AP, which caused an additional delay. Findings related to prior injuries should be documented in the file. Specifically, the "causal" relationship regarding the change in the diagnostic tests should have been requested from the physicians. File poorly documented for protest or appeal.</p> <p>The accumulation of all of these deficiencies resulted in an overall "poor" rating.</p>
4	0 of 1 bill paid within 60 days. SIF-4 was not completed within 60 days of notice or expiration of interlocutory order. Documentation of denial was not adequate.	<p>Summary: Lack of timely review of medical reports. CA made medical decisions that possible exposure does not relate to current medical conditions. CA appeared to make own medical decisions and misinterpreted medical reports. Diary dates were too long to allow for timely review of medical reports. Initial Interlocutory order requested timely but extension was not. Therefore denial was requested untimely, which may have contributed to filing of protest. Decision to appeal was not made quickly. Inadequate medical documentation combined with inadequate documentation about the nature of the exposure places the claim at risk during appeals process.</p> <p>If shorter diary dates and better efforts to obtain appropriate medical records (sound business practices) would have been employed, claim should have been resolved months earlier.</p>
Overall		

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Rating	Legal or Regulatory Requirement	Sound Business Practice
3	3 of 5 bills paid within 60 days.	No CA-initiated contact with physician. CA did not request records from initial AP regarding opinions on either PIR or notes. Did not clarify RTW or light duty issue. File indicates AMH released for full duty prior to 10-day follow-up appointment with AP. File silent as to whether IW requested return to full duty. Conflicting information about location of injury not confirmed. As a result of above, the lack of an appeal to the Allowance Order is understandable.
2	No comments.	File notes lacked substantiation of initial employee contact. Otherwise handled well.
1	No comments.	Claim handled well. Issue of appropriate treatment was proactive. Need for IME was addressed promptly. Protest and Appeals were handled well.
4	9 of 11 bills paid within 60 days. SI employers must submit medical documentation that concludes on the Permanent Partial Disability (PPD) assessment.	Claim was open too long and had to be reopened due to lack of proper medical documentation. Lack of proactive adjudication as there were long intervals between diary dates, which did not allow for timely management. Causal relationship should have been addressed/established when first note made in connection with PIR. File note incomplete as note stated that progress report indicated that condition was "fixed and stable" but it omitted that AP marked "unknown" for Permanent Partial Disability (PPD). Regardless, CA issued a closing order. Supervisor reopened claim after it was closed because IW had not received closing order and file did not address PPD.
2	4 of 10 bills paid within 60 days.	Initial diary was late so medical records were reviewed late. Otherwise handled well.
2	14 of 16 bills paid within 60 days.	No comments.
2	No comments.	No comments.
3	No comments.	Inappropriately long delay in scheduling IME and SIF-5 based on brief IME report. Written concurrence for a specialist should have been processed and retained in files. L&I upheld closure notice protest, but defense of an appeal could have been troublesome based on file.
3	No comments.	MRI should have been authorized on a diagnostic basis versus asking for PIR changes. Characterizing the AP as sarcastic in writing is inappropriate. L&I denied claim even though there was no signed concurrence by AP or preponderance of medical evidence. Therefore, documentation of denial is inadequate.
1	No comments.	Claim handled well.
Overall Rating	Legal or Regulatory Requirement	Sound Business Practice

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4	1 of 2 bills paid within 60 days.	(NOTE: IW was not responsive or non-compliant in most instances and the adjudication rating should be viewed in this context.)
		The initial diary was five months late and intervening diaries were also late. The AP was not contacted before closure, but should have been. There was no confirmation that AP ever examined IW. Because of history of the same or similar injuries, "back and forth" history of claim, lack of objective findings, potential of MRI evidence and IME should have been scheduled. A record of the last date of treatment and findings of examinations should be established. The IME should be provided as many past medical records as possible, but the file does not appear to have a signed release form. Without the above action steps the claim may not be readily resolved. With the above action steps, a stronger medical evidence case will exist at closing and will assist in any deliberation if a claim reopening is requested.
3	Request for determination was requested within 60 days.	This claim required more L&I adjudication than CCSI. Initial diary reviewed at 60 days. The subsequent diary date was set at 5 months later, but no reason for the long period of time was documented. It is possible that the long subsequent diary date was due to expected L&I timeframes. However, claim notes consistently indicated a diary for 30 days but this never occurred. More frequent review and more aggressive action might have secured a decision in a timelier manner, especially since this claim involved a significant reserve.
2	No comments.	Reserve appeared to be underestimated. Otherwise handled well for most attributes.
2	File is blank in addressing restrictions and the job to which IW returned. Thus, RCW 51.32.090 incorrectly applied.	Otherwise handled well.
2	7 of 9 bills paid within 60 days. SIF-5 reporting initial time loss payment was 30 days late.	A Segregation O&N request would have been appropriate for this claim based on AP report and results of diagnostic test and history. Otherwise handled well.
1	No comments.	Claim handled well.
3	12 of 13 bills paid within 60 days. No initial SIF-5 filed. No Total Temporary Disability (TTD) calculation sheets in file and no EAR calculation sheets in file and sheet is required to be attached to the SIF-5 Initial and no Employability Assessment Report (EAR) submitted.	No Total Temporary Disability (TTD) calculation sheets in file and no EAR submitted. Authorizing surgery and reviewing medical claims timely, but there were 3 diaries with large gaps. These gaps keep the claim open too long and expose claim to unrelated conditions.
Overall Rating	Legal or Regulatory Requirement	Sound Business Practice

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2	No comments.	Claim open 18 months, some of delay awaiting O&N and "back and forth" with L&I. Otherwise handled well.
3	SIF-4 120 days late, no interlocutory O&N requested while scheduling and awaiting IME.	Late SIF-4 did not appear to have adequate documentation. Language in physician report did not carry the needed weight. If a letter to physician had been sent at beginning, denial could have been processed earlier.
3	2 of 4 bills paid within 60 days. SIF-4 was not completed within 60 days of notice of claim. Inadequate documentation of denial.	Noted gaps in diaries and a lack of proactive medical management. IW claim of condition and AP support should be addressed with an IME.
3	1 of 3 bills paid within 60 days.	Simple claim was open for 1 year. While IW was not responsive gaps in diary dates contributed to the delay in closing the claim.

Legend of Undefined Abbreviations:

CA	Claims Adjudicator
AP	Attending Physician
IME	Independent Medical Examination
O&N	Order & Notice (issued by the Washington State Department of Labor & Industries (L&I))
PIR	Physician's Initial Report
IW	Injured Worker, who is the Claimant
RTW	Return to Work
AMH	Advanced Med Hanford
SIF	Self Insurance Form (various form numbers for various purposes).

Selected Legal and Regulatory Criteria:

Revised Code of Washington, Title 51 is the Industrial Insurance Laws. WAC 296-14 addresses industrial insurance and 296-15 addresses workers' compensation self-insurance rules and regulations. These WAC sections are the rules that provide practical interpretations and explanations of the Industrial Insurance Laws that aid in their implementation.

TTD/TPD Payments

First Payments Timely:	RCW 51.32.190(3)
Continuous Payments Timely:	RCW 51.32.190(3)
TTD/TPD calculation correct:	WAC 296-14-520
Correct number of days:	WAC 296-14-520
	WAC 296-15-420 (requires an accurate submission of the SIF-5A, the Time Loss Calculation Rate Notice)

Bill Payments

Bills paid per the statute of 60 days of receipt of final billing: RCW 51.36.085

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Early Intervention

Return to Light Duty:

RCW 51.32.090 applied.
RCW 51.32.090 applied.

Denied Claims

SIF-4 completed within 60 days/ Interlocutory Order:

WAC 296-15-420 (3) (4) In order to request a denial within 60 days,
the SIF-4 must be completed and submitted.
RCW 51.14.130 WAC 296-15-420(2) (3)
RCW 51.32.195 WAC 296-15-420(3)
RCW 51.32.055(2)
RCW 51.32.195 and WAC 296-25-420(3).

All records submitted to L&I with SIF-4:

Adequate documentation in file:

Re-Opened Claims

Re-opening Application forwarded to L&I Timely:

Provisional Temporary Total Disability due:

Paid Timely:

51.32.160(d): The department has 90 days to issue an order or it is deemed
granted, therefore timely forwarding of the reopening application pursuant
to the rule below.

WAC 296-15-480(2) WAC 296-14-420
RCW 51.32.190(4) RCW 51.32.210
RCW 51.32.190(3)

Other

Timely filing of an Initial SFI-5/WSIF-5A

Employability Assessment Report timely filing:

PPD Closure:

RCW 51.32.190(3) WAC 295-15-420(1)
RCW 51.32.055(2) WAC 296-15-510
RCW 51.32.190(3) (4)

Appendix C: Interview Summary

We have compiled the notes taken during the interviews into two summary documents. One document was used to capture comments from the randomly selected group while the other document was used to capture comments from the volunteer, or self-selected group. From these summary documents, we have further summarized comments by program components and the random versus the self-selected groupings. This Appendix C contains these summarized injured workers' comments.

The summarizations of the injured workers' perceptions of the process are highly subjective, both in terms of how the interviewees describe events and how we interpret comments. It is not necessary to validate statements made during the interviews, since the injured workers' perspective is valid, from their perspective, regardless of whether there are other facts and circumstances to help explain the individual situation.

There are many different, and in some respects, discrete components to the workers' compensation system utilized at Hanford. How well each step in the process was handled by the applicable organization or individual affects the Injured Worker's perception of how well the process worked for them. For example, in some cases all points in the process worked well. In these cases the injury or illness was taken seriously by the immediate supervisor, the initial medical treatment was provided timely and was effective, the employer representative was positively involved and helpful, ongoing medical treatment was helpful, the claim was processed timely, the time loss or medical bills were paid promptly, the independent medical examination (IME) was professional and helpful, the claim was closed appropriately and the injured worker was treated well in all aspects of the process. Unfortunately in other cases, very few of these process components worked well. When many components fail for any individual claim, the injured worker's perception of the process is understandably poor. In addition, the manner in which the injured worker became involved in the process also has a significant influence on their perceptions. For example, some claimants became involved through various studies or initiatives (i.e., initiated by external organizations) while others were self-initiated from a specific incident.

Notes about interview summaries: The male gender (he, his, him, etc.) is used for all cases including female injured workers. HEHF stands for Hanford Environmental Health Foundation. This entity was succeeded in 2004 by Advanced Med Hanford (comments use AMH or Advanced Med). The interview participant is referred to as the Injured Worker. We also use the abbreviation "IW" to refer to the Injured Worker. AP is short for Attending Physician.

Brief descriptions of the situations experienced by these individuals are provided in the final section of this Appendix C.

WORKERS' SUGGESTIONS FOR IMPROVEMENTS

We asked the following question during our interviews: "Since we are interested in ways to improve the entire workers' compensation system at Hanford, what advice would you give us in terms of areas that need to be improved, and what are your suggestions for improvements?"

Random Selection Response:

Comments related to improved communication, working relationships and enhanced assistance in the process

- Four recommendations: 1) Need better communication of what are their rights. 2) Invitation to discuss medical condition with persons who can help initiate a claim (elderly and retired need help); need an advocate (since CCSI is not and no longer have an employer representative to go to for help). 3) Understanding and evidence of fair treatment of Hanford workers, so far it's pretty dismal. 4) Need a process in place to assist with appeal of decision or on reopening case.
- CCSI should inform Injured Worker up-front what to expect and notify in advance of actions being taken (warning that time-loss payments (TL) will stop). Adjusters should know the process better.
- Injured Worker didn't get anything in the mail during this time, which would have been nice because he always had to call to find out what is going on. Especially since they know that they should share this information with the Injured Worker.
- Should be more informed in advance of a decision so that Injured Worker could be more effective communicating with doctors, etc., before getting the "closed letter"
- Kept in dark regarding billing matters & how to go about the process, but Injured Worker admits he didn't ask for help.
- More education is needed, so that people understand the process. Injured Worker introduction to process was by UW, dealt only with UW. Need good communication because the administration of program is big black box, who does what? Who are the parties and what are their roles. UW would take care of his problems (they managed case).
- Confused about letters stating claim denied and then still open, letter about turning over claim, more explanation would be better, he would like to know what's going on.
- Injured Worker thinks that there must be some incentive to save \$, but CCSI should be able to help people instead of being a hindrance. CCSI didn't do their job like it is supposed to be done. CCSI is in a position to help people, but it seems like they try to get you to give up. They didn't forward information they had. So recommendation is to be more

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- helpful to the Injured Worker and share information they have. This is a simple claim that is proven; yet it took 7 months to complete.
 - If injury occurs there should be a first step to document (one page check list) that Injured Worker was advised of the process and his options explained. There is no point of contact to help out if there is a problem/disagreement, no one to go to for help. Employer should help follow up on problems.
 - More information about how to go about process, he feels like he is not doing it right but he is not sure what right way is. Both employer representative and CCSI could do this.
 - With CCSI its "we versus them" (adversarial) and that is not how it is supposed to be. Even though he was a victim, CCSI made him feel like the offender. Injured Worker recommends that CCSI be more helpful. During start of paper work it would be helpful if employer advocate and CCSI got together to lay out the process so Injured Worker could know what to expect & what to do.
 - CCSI needs to be friendlier and more willing to work with IW.
 - Some confusion about overlapping programs. He gets a letter saying he might be eligible for \$150,000, but only if he dies. But otherwise, he gets good correspondence from both programs and loves the annual checkup.
 - CCSI denied the claim without one personal phone call or direct face-to-face contact. CCSI should do that before they reject a claim as IW could have clarified the problem and the appeal process could have been avoided. There should be a mechanism for the IW to see what the employer is submitting regarding the injury so that errors can be detected and corrected early in the process.
- Comments Related to Process Improvements or Medical Service Issues**
- Work on the file whenever anything comes in and take care of it right away. Get process straight don't keep changing mind or decisions.
 - Relieve CCSI caseload so that they can be more responsive.
 - HEHF used to be open 24 hours, AMH now open till 11:00PM but off shift workers can only go to town, need a nurse practitioner or RN 24/7 that can help out with injuries. The 30-minute difference in treatment time can make a difference. Need more information on what actual process is. If they had that, the employee advocate wouldn't be needed.

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- Doctors need to be better able to handle the type of illnesses out at Hanford.
- CCSI should build up data on Hanford hazards situation to support why they denied claim (and then adequately explain it). CCSI should not stop at the Independent Medical Examination conclusion when it differs with Attending Physician, a third really independent exam should be used for a tiebreaker.
- Employers view serious injuries, e.g., chemical exposures, as happening away from work. Recommendation is that employer take responsibility for the work related illness.
- Involvement by management should be at a higher scale, Injured Worker had to push and get angry in order for them to take the injury seriously. CCSI should not be in such a hurry to close a claim; with just a little extra treatment the medical condition might have been resolved.
- IW thinks that the screening for individuals who are sent the UW survey should be tightened up. There is no reason to hype up potential problems, just to prove that nothing is wrong. They shouldn't bother anyone else but those who have real problems. UW shouldn't put an idea into IW's minds that there is a medical problem when none exists.

Positive Comments

- This Injured Worker process worked just fine but had heard about many others when it didn't work well at all.
- No suggestions, IW understands that there is a process that must be followed and that it takes some time. Even though result was not what IW wished, the process worked well.
- Nothing to recommend as the process worked well for this Injured Worker.

Other Comments

- Pay up without having to die or lose a body part to prove the obvious.
- Fix whole process. There are too many irons in the fire, too many people and organizations involved.
- Would like it to be back under L&l like in the old days. CCSI should care more for people.

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Self-Selected Response:

Communication and Process Comments

- Improve communications, return calls, talk to the injured worker and explain what is going on (if CCSI had done that outcomes would have been better for the Injured Worker and the doctors as well). Don't harass the independent medical examiner. Recognize need for a specialist.
- Provide claimant with more information about the status (what is going on). Provide an ID card with claim number. Streamline process of getting the needed information into the file to reduce delays. Upon request for file, provide the entirety of the file (don't leave out certain documents)
- More availability of health advocates, as people need the employer to help.
- A program similar to the Help program run by the AFL/CIO would be useful at Hanford.
- Process filing more quickly and make it easier. Injured Worker should not have to chase after CCSI to make sure all is right and not have to face constant evasion.
- Is OK to look hard at fraud, but once a bona fide claim is established, CCSI should quit fighting. If CCSI misses or loses documents, they should follow-up immediately. Sometimes Injured Worker needs a caring person.
- Let people know up front why there is a delay and how the claimant might resolve the problem. Quicker payment of bills and benefits. The 60-day requirement is too long, (Law needs to be changed?) Explain process with a DOE training program. Use a postcard similar to L&I's with claim number and what is covered/allowable.
- Go through rules up front so that Injured Worker knows what to expect. This could be done by CCSI or by company, union, etc.
- Recommend to have only one office to go to that can handle everything including looking up DOE data on who worked in radioactive areas or asbestos and if they worked in those areas during the time period, process their claim.
- Don't switch CA during middle of claim. Seriously consider honoring request to have a second CA opinion or a new assignment altogether.

Medical Service Comments

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- There is a need for an epidemiologist to track groups of people who are sick. Pay claims more timely and have state L&I more involved.
 - Take care of problem early, don't put off treatment, could have avoided a month of pain if it was handled correctly. Get problems that doctors have with L&I/CCSI fixed so that Injured Worker can use doctors.
 - Go with personal doctors' opinions. CCSI fights constantly and pushes Independent Medical Examination opinion. Get Independent Medical Examinations done quickly. Get rid of CCSI and go back to L&I.
 - CCSI treatment of Injured Worker by staff needs to be improved, let Attending Physician be the doctor not CCSI. CCSI should not try to manage medical decisions. CCSI's attitude should be more kind and caring, remember that the Injured Worker is hurt and that they need a higher level of compassion. Don't delay necessary diagnostic procedures.
 - Give the proper tests to prove what happened to workers then provide a pathway to getting better. Let APs and specialists give the right (diagnostic) tests. CCSI needs to allow costs for a Chemical Exposure Specialist.
 - Company should test the exposure immediately, document the specific chemicals involved in the exposure and provide documents to Injured Worker. AMH needs an epidemiologist and a toxicologist, they also need to provide the autoimmune test that is from a CLIA certified lab. DOL needs to get that medical card out to people.
- ### Organizational and Other Comments
- Eliminate safety bonus incentive.
 - Want unbiased investigations going back 6 years, full recompense for those suffering yet denied, and oversight of Advanced Med. Company HR folks are dishonest, return to work judgments are not right (by HR).
 - DOE should be open and honest about their responsibilities to provide a safe workplace. DOE wants to shed long-term liabilities and shouldn't be able to hide behind "National Security" anymore.
 - DOE needs to be decertified as an SI employer. DOE had other internal reasons for denying workers claims (don't want to admit hazards).
 - Segregate point of contact for CCSI and EEOICP, two different individuals (perceived to be a conflict of interest). Use local consultants, not ones from Texas.
 - CCSI go away and go back to L&I.

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- Have the corporations handle their claims instead of CCSI or go back to L&I. Company can't do anything right now.
- This person wishes DOE would go back to the old L&I process.
- Go back to L&I, and if not that, get a new contractor other than CCSI.
- Go back to L&I. This Injured Worker has gone through both.
- More timely processing. Why have a "Middleman" instead of just direct to L&I.
- CCSI should just "go away".

COMMENTS ABOUT SPECIFIC WORKERS COMPENSATION PROCESS COMPONENTS:

Overall Rating of Satisfaction by Component: Random versus Self-Selected Group (Scale of 1 to 10: 10 being the best possible response and 1 being the worst possible response):

Satisfaction Rating Component	Random	Selected
Self		
1. The case management of your worker's compensation claim	6.06	1.89
2. Your health care treatment	8.03	7.39
3. Your workplace accommodations	8.30	5.09
4. The processing of your worker's compensation claim	6.97	2.61
5. The assistance provided by your company (contractor or subcontractor)	6.96	4.00
6. Help in resolving disagreements related to your claim by L&I or others	5.88	4.90

Was this the first time you ever filed a claim? Yes reported

21 out of 31 2 out of 23

Most of our focus in using the interview technique was to obtain an understanding of individuals' perceptions of various components of the overall workers' compensation program. The comments provided in this Appendix C help to explain the ratings provided above and provide a rich context, within which the average rating and the differences (or similarities) between the randomly selected group and the self-selected groups may be better understood.

Random Group Comments:

Employer Representatives and HEHF/AMH:

Employer representative helped out with paperwork, HEHF also helped out with providing records. Employer representative was not real effective, had to make many phone calls to them because they didn't let him know what was going on. He kept getting bounced between HR person and CCSI (felt like Injured Worker was stuck in the middle between HR and CCSI). AMH did what they are set up to do, mostly minor stuff. Employer rep was nice, HEHF never did anything, but their tests were how he knew about the issue. Employer representative did a great job, it was HR who managed the case for him and answered all of his questions. AMH was very effective and treated Injured Worker with respect. Safety guy was helpful in some discussions. AMH was helpful. Had no contact with HEHF regarding claim, they just follow standard procedures and refer to Injured Worker's private Doctor. They were therefore neutral, not overly helpful & not too unhelpful. HR person was helpful and concerned. The first AMH Doctor was angry with a letter from Attending Physician on conclusions, and then went to first Doctor's boss and he was more helpful. Employer representative wasn't around at all, just pushed through the paperwork, but they're getting better at explaining everything. Employer representative was helpful in setting up claim but didn't go "head-to-head" with CCSI when Injured Worker could have used the help. Medical providers told Injured Worker what the steps were. AMH did some follow up but not often. No employer representatives involved (as he is retired). The HEHF radiation detection group does tests, but he never gets any reports back. Employer representatives were not helpful as he is retired. Didn't have employer representative as Injured Worker is retired, doesn't like that 'they' deny that working at Hanford causes cancer. Employer representative was excellent, did paperwork, never had to deal with CCSI. HEHF was OK for first aid. Had two different employer representatives and both were very helpful in terms of completing certain paperwork. Injured Worker thinks that HR was involved and also helpful. AMH was helpful, had to go to them several times in that they put a lifting restriction that increased over time. Employer representative wasn't involved at all. Initial medical providers were helpful. There was no employer representative involved but supervisors, etc., were good about telling Injured Worker to take care of injury. HEHF was helpful in treating injury but wasn't responsive to certain questions. Had little interaction with employer representative, but was informative enough to let Injured Worker know what is going on. Initial medical provider was very effective. Employee advocate was very helpful but the initial medical attention was very poor. Employer representative is very helpful, laid out paperwork and process ahead of time. HEHF was average but OK, they are there just to document that you came in and had a claim. Employer representative was very helpful and initial medical providers were also very helpful. Most problems were personal attacks by GAP (Government Accountability Project?), without any basis for the allegations. HEHF opened up lots of records to the department of health, which didn't follow-up based on their review of documents, no basis to pursue. Also had an office of Inspector General (OIG) review with no findings but folks refused to accept the results. Past records are well managed in the Seattle repository, so there is not much of an opportunity to change the records. Employer representative was not helpful because they delayed paperwork on purpose so that CCSI could use it as a reason to deny claim. (Consultant's note: this Injured Worker has a hard time telling the difference between employer

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representative CCSI and L&I) The Injured Worker likes HEHF & AMH. Employer representative was helpful but didn't provide all of the important information, which caused a delay in their return to work (RTW). AMH is all right at looking you over and they go over L&I stuff pretty well. The distinction between Personal Injury (PI) time, short and long-term disability is fuzzy. There is no employer representative that Injured Worker is aware of. Never saw a real doctor at HEHF only PAs, they just refer to Attending Physician, who is great. Employer representative very helpful provided all of the information that the Injured Worker needed and they helped with paperwork, gave their card and told to call anytime if there is a problem. Pleased with HEHF, the Injured Worker didn't request restriction but they offered it and PA set up all of the specialist tests. There was no contact with employer as IW was an ex-employee and there was no need as UW helped in the process. Had to spend a lot of time convincing employer representative that there was pain, they kept brushing off Injured Worker but once claim was filed they had to deal with it. Employer representative took a very long time to look into workstation configuration issue. HEHF was very good and helpful in dealing with medical issue. Employer representative was not helpful as IW did all of the work on own, with some assistance from UW. Employers made incorrect comments on the claim form about the injury, which caused some processing problems. Employer did offer to go to first aid.

Note about workplace accommodations: We included a specific question about workplace accommodations such as a light duty option. In general, the random group was complimentary about workplace accommodation. The separate answers given for the question "**If your situation required an extended time away from your normal work assignments, was an alternative assignment or "light duty" option provided by your employer or possible options explained by any other organizations?**" are provided below. We also asked if the arrangements were satisfactory. Specific responses to these questions are as follows:

Yes, 100% satisfied. Yes, Excellent. Yes Fine. Yes, satisfied with arrangements. The first time yes, but currently its N/A, as Injured Worker didn't let work know. Yes, satisfactory. Officially, it's a 100% or no work policy, but supervisors provided a "softer" job for a couple of weeks.

No, but they probably would have provided an alternative assignment if they weren't short handed. Wasn't provided a "light duty" assignment and did same job, but that was OK with Injured Worker. No, but it wasn't an issue. No, but thinks they would have. Had opportunity, but it wasn't relevant or necessary. No his company wouldn't allow that, it is 100% or don't work, so he has to work with the injury and the pain. No, this option was not provided.

Personal Medical Service, Specialist and Independent Medical Examinations:

Personal medical providers were not helpful and the equipment doesn't work well. Attending Physician was good about explaining what to expect. Independent Medical Examination was a bad experience, had to wait a long time for the appointment, some weird questions and tests, not too professional. Even though report was wrong, recommendation was same as Attending Physician (just for a different reason). Doctor was very effective, had heard good thing about doctor from

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coworkers. Attending Physician did a good job and physical therapy was outstanding and sent in the paperwork to CCSI. Believed UW medical folks had an agenda to prove that all Hanford employees were sick, and other medical services providers were just OK, not too thorough. Attending Physician and specialists were good. Medical service was good. Thought Independent Medical Examination was a joke. Attending Physician service OK. Independent Medical Examination was a very thorough exam 3-4 hours. Initial medical providers were prompt in what they did and other service was "A-OK". Injured Worker hasn't dealt with CCSI, just tells medical providers it's an "L&I claim", but he thinks they bill his medical insurance. The Independent Medical Examination was very helpful. Independent Medical Examination was OK; they did their work and gave a report. Medical providers were good. Medical service was good at instructing physical therapy on what needed to be done. Injured Worker's Attending Physician good but specialist conclusion is wrong as the injury continues to bother Injured Worker. Doctors didn't resolve issue. Attending Physician is helping. Attending Physician helpful but was somewhat limited in what Attending Physician could do for Injured Worker. Specialist was fair to poor, couldn't find anything and didn't want to follow up on it. Attending Physician and tests were very helpful, they were systematic, knew most successful route and how to get through the process. Attending Physician is great. The Independent Medical Examination was stupid in that they even used one. Independent Medical Examination was "hokie", did a thorough exam and report conclusions were correct but why send him to an out of town doctor that doesn't know anything about Hanford or tank farms. Attending Physician and specialists are helpful. Harborview was helpful and did a thorough examination. The IME process was fine. Attending Physician was good and helpful in filling out claim. UW was OK, did the tests, brought up red flags but didn't do anything after that. Medical treatment including AP and specialist was very good.

We included the following specific question about Independent Medical Examinations in our interview: "**Did your situation require an "Independent Medical Examination"? If so please share your impressions of that process.**" Some of these responses either duplicate or restate some of the responses above.

Didn't like it. Doctor was trying to determine if he was telling the truth, which he resented. The examination was professional. Independent Medical Examination was a joke (maybe just like all doctors, some are good and others are bad). Independent Medical Examination didn't know much and conclusion was not accurate. Independent Medical Examination was a normal test just a little more extensive. Just one of a 1000 cases run through their process, but believes organization was efficient & effective in general (non-L&I cases). Independent Medical Examination process doesn't work well. Some doctors OK while others are not professional and don't have medical histories, so how can they make conclusion just by asking a few questions? Thought it was a joke, didn't come to right conclusion until tests were reviewed, other Independent Medical Examination's conclusion was not correct. Was a thorough exam, CCSI scheduled it. Excellent, professional exam and it was conducted at his convenience. Independent Medical Examination was OK. It was silly to have wasted \$ on an Independent Medical Examination when a few Q and A's would have resolved the issue. Exam and report were good but why can't you use a Tri-Cities doctor that understands Hanford and tank farms. Independent Medical Examination was OK.

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CCSI:

CCSI kept going back and forth on the same issue for several months; it shouldn't take a year to handle a simple claim. They should be able to manage a claim more often than only once a month. Had trouble with CCSI, they changed staffing, didn't give advance notice that TL checks were to stop, they just stopped, resumed when Doctor submitted new paperwork. CCSI made some errors and they were difficult to get corrected. CCSI took a long time, but he didn't experience any snags because they told him what to do and he did it and it was OK, so Injured Worker can't really complain. Had no oral contact with CCSI, just a letter, but didn't have any problem with them. Had no contact with CCSI at all, as far as he was concerned UW was managing claim. (This happened around 2000?) Heard nothing from CCSI until received "closed letter". Injured Worker got the impression that this case was just another file to run through the process and believes others feel that way as well. Claim is open so can't say much about CCSI. CCSI was good. Didn't deal directly with CCSI (except for maybe two phone calls), mostly through mail with letters explaining things to him and he didn't have a problem with them. Went a couple of rounds with CCSI, feels like they "sprung" things on Injured Worker. Had some conversations with CCSI but mostly just letters, they weren't accommodating when it came to scheduling Independent Medical Examinations. With CCSI you just send in forms, there is no face to face and they are not particularly helpful. Why did "they" (CCSI or EEOICP) quit checking him out? CCSI are nice but didn't get anywhere, it was like they ignored the case. No contact with CCSI. Only had one interaction with CCSI, hard to get a hold of so can't say how effective they were in helping Injured Worker. Injured Worker assumes that CCSI was authorizing the treatment that Attending Physician suggested. Regarding CCSI, Injured Worker had to send a lot of redundant paperwork that Injured Worker had sent earlier. Injured Worker thinks that they were working mostly to avoid any payment. While didn't agree with CCSI decision, thought that they were thorough. There was no flexibility to help correct someone else's error. They weren't concerned for Injured Worker's welfare. Haven't talked to CCSI a whole lot. Injured Worker calls but usually they are not there. The accepted letter took forever, Injured Worker thinks he didn't follow procedures correctly, but he doesn't know what the correct procedures are. Don't know about CCSI because disputes are under review. Claims processors were awesome, never had a time when CCSI did not respond quickly to calls, questions and problems. Didn't have any contact with CCSI so it's hard to make an assessment on how helpful they were. Injured Worker impression of CCSI is that they are there to make sure claim is denied. CCSI is not very helpful, hard to get a hold of, never know what is going on with claim unless Injured Worker calls and bugs them about it. Bills got paid but Injured Worker didn't know where things stood. Never got notified that treatment was approved. CCSI is not helpful at all; they are there to get Injured Worker back to work so they don't try to be helpful. CCSI is helpful but didn't explain up front that all billings are to be sent to them. Has no recollection of significant interaction with CCSI. CCSI was thorough and was as helpful as IW thinks they could have been. CCSI was kind of "pushy", told to keep going to doctor and constantly challenged on whether physical therapy continuation was necessary. They were pushing to close the claim. IW had no direct contact with CCSI, all done via mail. Had no direct contact with CCSI, they initially turned down claim but specialist disputed that conclusion. Once L&I overturned CCSI denial, everything went well.

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Note about CCSI. We included a question during our interview that asked specific questions about CCSI. The question we asked was: **In your opinion, how well was your claim processed. For example, were phone calls returned promptly? Was the claim adjuster courteous and helpful? Were your time loss benefits and/or medical bills paid within a timely manner?** The following are responses to this question:

There were eight (8) responses, not included below, stating: Yes to all of the above questions about CCSI. These individuals were pleased with the interactions and results from CCSI.

Phone calls were returned after about 2 days but they never called him. Claims Adjuster was nice. Having to go back and forth about the adequacy of tests and records and changing their mind was not helpful at all. Only working on the case once a month is not helpful. CCSI didn't explain much to him and he has to do a lot of work to take care of them. They were moderately courteous. CCSI was courteous and helpful. CCSI was fair about returning phone calls; adjuster was courteous and, to a certain degree, was helpful. He had to do a lot of follow-up and they did make some mistakes. TL payments were late at times but generally timely. CCSI did not return calls promptly and sometimes he didn't get a return call at all. CCSI was courteous and helpful. As far as he knows, bills were paid on time. CCSI phone calls were returned, he was treated fine, they were helpful, and he assumed bills were being paid because no ill reports from doctors. All of the questions are N/A since he had no direct contact with CCSI other than letters. Medical bills were not paid promptly as the physical therapy complained about this. All of the questions are N/A since had no direct contact with CCSI. CCSI answered the phone calls and were courteous and helpful about half the time, but they didn't send the medical records to the Independent Medical Examinations before the examinations, which is very disappointing. Bills are not getting paid on time because of calls from doctor, but claim hasn't yet been accepted or denied, so doctors understand. CCSI returned calls about half the time, the claims adjuster was not courteous and not helpful. Thinks bills paid on time because heard no complaints from doctors. Calls were returned, if he had question they would answer. They were courteous and helpful in most cases. There was a bill payment problem when he kept getting bills from the hospital. No contact with CCSI so most answers are N/A but thinks payment timely as heard no problems from doctors. CCSI was pretty good about answering questions but they are hard to get a hold of. They were courteous but most of the contact was Injured Worker answering CCSI questions (not the other way around) so they weren't that helpful. CCSI did not return any calls; Injured Worker has to call when they didn't return calls. While the claims adjuster was somewhat courteous, they were not helpful. Thinks that the few bills were paid on time. CCSI returned phone calls pretty well overall. Not necessarily courteous but professional and they were helpful. Bill payment was good, very responsive. CCSI hard to get a hold of but they do return calls promptly; the adjuster was courteous and helpful and is paying medical bills on time. CCSI assumes that you know what to do, they are good at answering questions but don't volunteer information. Mostly yes, but doesn't have a recollection about how Injured Worker was treated by CCSI. Medical bill payment is N/A since employer covered all costs and nothing was run through CCSI. CCSI was courteous, not helpful, and bills were paid on time. Phone calls were not returned but CA was nice and helpful most of the time (got a lot of "we are waiting to hear back") when Injured Worker knows they got the stuff. No to all except that medical bills got paid timely. IW

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did not have direct contact with CCSI, it was all via letters, they rejected claim when they shouldn't have but L&I reversed it.
After the L&I decision all bills were paid in a timely manner.

EEOICP Resource Center and Department of Labor:

EEOICP local resource center was helpful in filing claim but then doesn't do much. Seattle office OK but they don't do anything either. EEOICP were nice people, had a good meeting but haven't got anywhere with them. EEOICP folks were very helpful, moved Injured Worker through the processes well and received a card for future problems. Injured Worker thinks has an EEOICP claim but it's been in limbo for 5-6 years. EEOICP representatives were helpful in that they were good at answering IW's questions. Took years to get a DOL card.

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L&I was very effective in being helpful, they answered all questions and were very responsive. L&I wasn't there to help, just there to expedite the closing of the claim. L&I was helpful because they caught the employer error, that it was not the injured Worker's error, and then allowed the claim. Regarding L&I, just got letters from them no other interaction. L&I is helpful but slow. L&I was helpful in that they considered IW's additional information and arrived and the correct decision.

Self-Selected Group Comments:

Employer Representatives and HEHF/AMH:

Employer representative was initially helpful about how to file a claim. Employer representative was helpful in getting paperwork started and then he was left on his own. Wage information was wrong, as it didn't include overtime. HEHF was OK except for Beryllium issue; they are too quick to clear for return to work. Company representative did give advice on what steps to take, they advised against going through CCSI. The company can take a long time to help if there is a dispute. Told to go to HEHF, which did nothing (they are crooked) they refused to provide medical records. Advanced Med, made a "release" determination too soon. HEHF/CCSI (in collusion?) denied that the injury was work related, but this was countered by a private hospital. There is a problem with safety department not wanting to recognize that an injury had occurred (discouraged filing an L&I claim) but others in company have been helpful. One guy in the company was helpful. However, there is an incentive for the company to minimize claims because of safety record and bonus and they want to appear to be

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cost efficient by discouraging claims, so you see this in many different parts of the company. Employer representatives were very bad, they tried to get him to change the date of injury to a different year (to play with safety record statistics). Employer rep was very helpful, but regarding HEHF, some people there were trustworthy while others were not. Employer rep is OK. Would not call Advanced Med doctors, they are not good. Employer contacts were helpful. Employer rep was pretty good at being helpful. HEHF blew off that an exposure had occurred. The company rep at time of injury did help with paperwork but it was an adversarial relationship. The new employer rep is good. The hospital did what HEHF told them to do. HEHF had a director who wrote a horrible diagnosis and their Physician Assistants (PA) are not good. Advance Med's director is better, but they have PAs from the old company, so still not so good. Once PA wrote a poor diagnosis after only a 5-minute exam. Company was OK; AMH didn't take injury very seriously. Employer representative was very good, but Advanced Med looked only for the immediate, not thorough, so they tend to discount injury, they were not too helpful. Employer representative was helpful and initial medical service is fine. Management was good; worked with HEHF; and HEHF was good about stating the need for a restricted duty. Company management got directly involved with CCSI and they were very helpful. Employer rep used to be good at helping out with CCSI but now only helpful about half the time. Regarding HEHF, if you get the right doctor, it's OK, but Injured Worker does not trust the initial ones. The annual exams have been cut down quite a bit. Employer representative was very poor at helping even though restrictions agreed to between Attending Physician and AMH; there was no change in job assignment, no analysis of required work provided to Attending Physician. AMH was satisfactory. Employer representatives do not help but are a hindrance. AMH has no toxicologist or toxicology tests and those are needed along with epidemiologist and autoimmune tests. HEHF/AMH is in an adversarial relationship with Injured Worker as their general response is "go back to work". HEHF doctor misrepresented qualifications. Filing an L&I claim created some type of retaliation (in varying degrees). Data about incidents didn't or no longer exists (no OSHA notes, no plant log entries, etc, how can a worker prove causation when don't have an idea what they were exposed to?) Had no contact with an employer representative, but HEHF was very helpful. Doctor at HEHF was helpful but believed the computer version of chart notes were intentionally incorrect.

Note about workplace accommodations: We included a specific question about work place accommodations such as a light duty option. In general, the random group was complimentary about workplace accommodation. The separate answers given for the question "**If your situation required an extended time away from your normal work assignments, was an alternative assignment or "light duty" option provided by your employer or possible options explained by any other organizations?**" We also asked if the arrangements were satisfactory. Specific responses to these questions are as follows:

This self-selected group had a more mixed response as compared to the random group

Yes provided, manager could decide what kind of work could be done within restrictions. Yes, he was provided an alternative assignment and was satisfied with the arrangement. There was no "official" light duty provided, but boss helped out with the physical stuff. Didn't worry about whether there was an official position because boss took care of it. Yes, he was provided deskwork. Yes, satisfactory, they provided new equipment. Yes, it was OK/fine. Yes, the arrangement was satisfactory.

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N/A had had a desk job to begin with. Didn't need an alternative assignment but a different location was provided. Yes, the arrangement was satisfactory.

No official light duty, he has concerns that no vocational testing was conducted. Collective bargaining agreement says eight (8) hours or nothing, he could have done light duty for 4 hours but none was offered because of agreement. Light duty was provided, but the work crept into regular work before long (didn't help physical problem). No, policy is "fit for duty", but it is not consistently applied. Company thought it was light duty but it was the same as before the injury (production comes first). Yes provided, but not satisfied, sent home mostly. Yes, it was satisfactory, but after about 6 weeks, job assignment crept back into normal assignment. Didn't fight it because was tired of being told Injured Worker was OK, so gave up and resumed normal duties. No, but this is N/A. No, but there should have been. Most folks are not provided an alternative assignment. Even when AWH and Attending Physician agreed about chemical sensitivity, employer put back in same place so they disregarded the restriction. Yes, but the arrangement was not satisfactory, was isolated. Needed equipment that CCSI withheld and it wouldn't be easy to use in a workplace situation. Injured Worker believes that once a disability is discovered they are allowed to fire them; "how else do you think we can get rid of these people".

Personal Medical Service, Specialist and Independent Medical Examinations:

IW had a bad experience with medical providers. Medical providers were OK, but the Independent Medical Examinations were not professional, just a "front" for CCSI/DOE. Independent Medical Examinations are not necessarily specialists and may not be practitioners. All medical providers including Independent Medical Examinations were good. Medical providers were OK. Independent Medical Examination OK, as it confirmed the diagnosis, but got the date of injury wrong, so who was employer when it happened? (Consultants Note: This person raises an important point about the structure at Hanford, many different contractors all working for DOE, people can move between companies or change jobs when contractors change. If something happened and the time of exposure can't be pinpointed then who is at fault is difficult to determine, and all companies will be trying to avoid responsibility.) Advanced Med is OK; kind of a first responder and other medical treatment is good. Independent Medical Examinations are a joke. Independent Medical Examinations were bad; two doctors spent a total of 15 minutes without any background or file information. They appear to be doctors for hire. Medical treatment was good but doctor won't deal with L&I (CCSI). Independent Medical Examinations are very bad. Medical treatment from private doctor was good. Own medical treatment was good. His doctor is fine except that paper work was not perfect so certain time loss was denied. Independent Medical Examination was horrible, rude, unprofessional, intimidating, "bullying". Independent Medical Examination was a joke, too short and not thorough. Independent Medical Examination turned out as not effective at helping, as one was just a "company man". Medical treatment was fine. Independent Medical Examination was impressive, very nice, asked good questions and listened. Independent Medical Examination never examined him and did not take a pulmonary function test. Said he had looked at the records that were sent him (but IW didn't think that he had). Injured Worker believed Independent Medical Examination decision was made before visit because it was going to be a

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decline but additional information changed his mind. AP and specialist are helpful but they are limited to what CCSI will pay for. Certain tests (such as a toxin blood test) are too expensive. Attending Physician was unsatisfactory, poor in helping because couldn't deal with paper work and Attending Physician should have known. One Independent Medical Examination had a favorable outcome and the other did not. Specialist was not as helpful as the IW's Doctor. Independent Medical Examination was not helpful, was rude, didn't seem interested, from visit it was clear that Independent Medical Examination would not provide a favorable report. Independent Medical Examinations were bad. Doctor is biased, anti-worker, anti-chemical exposure, therefore didn't get a fair examination.

We included the following specific question about Independent Medical Examinations in our interview as follows: "**Did your situation require an "Independent Medical Examination"? If so please share your impressions of that process.**" Some of these responses either duplicate or restate some of the responses above.

First report was fine, but then CCSI forced some changes that were not OK. CCSI didn't allow a specialist until L&I made them approve one. Sent to three (3) Independent Medical Examinations, questions why some were selected because expertise didn't match the claim's need. As discussed above, IME was not professional, viewed as too close to CCSI and DOE. Both were good. It's a joke. Not competent, a bad process. Doctors were courteous, but he didn't like the outcomes. IMEs were "half-assed" exams, not thorough except for the last one (he did x-rays when none of the others did). Very poor, Injured Worker was bullied, intimidated and they acted grossly unprofessional. The exam was very painful. This was a joke, was not a good exam because it was too short. Two Independent Medical Examinations, the first appeared competent, the 2nd was the "company doctor" and the difference in interaction was like night and day between the two. Was surprised that CCSI only listened to the negative doctor. Process was "scary" because Injured Worker didn't know it was a normal process and thought it was just a way to get out of paying medical bills (based on previous interaction with CCSI). But once exam was held, it was positive, good and pertinent questions were asked; Independent Medical Examination listened, seemed competent. Independent Medical Examination was very poor, would not have approved claim if Injured Worker hadn't challenged Independent Medical Examination on some facts and provided additional information. Thinks the Independent Medical Examination was compromised by a conflict of interest. The Independent Medical Examination did a good job and conclusion was same as Attending Physician. Injured Worker thought this was a waste of time; Independent Medical Examination was not interested in considering background and other information. CCSI prefaces all Independent Medical Examination visits with cherry-picked medical reports to manage the Independent Medical Examination report. Once they get the Independent Medical Examination report they want the Attending Physician information and opinion was discounted. There were a lot of records to support the claim but they didn't end up in the claim file because various people and entities withheld them.

CCSI:

Treated poorly by CCSI, they wouldn't pay time loss because they didn't have enough information. Doctor had to resubmit bills. DOE states that they review documents going to Independent Medical Examination, but he doesn't believe that is true.

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CCSI is a problem, will no longer communicate via phone, only in writing. They are not rude but do misstate facts. Getting the claim started was difficult. Referred to Rainier (a CCSI subcontractor?) with a conflict (family members in both CCSI and Rainier?), not a good result because physical therapy was not handled well. CCSI is not helpful they focus on deflecting claims from DOE. From initial stage CCSI denied right away. CCSI is very bad, they are obstructionists, they are there to save DOE \$. Once the validity of a claim is established they should back off. CCSI takes forever to get things done. CCSI is very bad. Had some frustration with CCSI at beginning, had to use vacation time and didn't get paid for part of the time off. However, CCSI was proactive about managing claim once it was approved. CCSI has not helped, they have been a pain from the beginning, many doctors have been involved, questions Attending Physician (AP) constantly. Consulting nurse challenged the Attending Physician. CCSI is interpreting medical information instead of taking Attending Physician opinion. Independent Medical Examination went well, but expects that it wouldn't have if he hadn't brought all of his paperwork since CCSI sent only certain stuff. CCSI was not helpful; they were obstructionists. CCSI used state law not to pay; they are not medical practitioners, just adjusters. CCSI was not helpful, they would call and pick arguments with claimant, and they were rude. CCSI claim processing was horrible. CCSI, it took too long to find out if it was a valid claim (about 9 months). CCSI was unhelpful, counter productive, lying to company management and this really upset Injured Worker. CCSI is extremely poor at being helpful. CCSI was very poor in helping. Claims processors are not helpful. IW's Doctor didn't want to deal with L&I claims (CCSI). CCSI was not helpful, more of a hindrance. CCSI denied paying costs for immediate emergency medical attention so the medical providers went after the Injured Worker.

Note about CCSI. We included a question during our interview that asked specific questions about CCSI. The question we asked was: **In your opinion, how well was your claim processed. For example, were phone calls returned promptly? Was the claim adjuster courteous and helpful? Were your time loss benefits and/or medical bills paid within a timely manner?** The following are responses to this question:

Very few calls were returned, he received rude treatment and they don't seem to care. Involved cases may be too expensive for them. Medical bills were not paid timely. Asked for copy of file, received only portions of the file. Payments stopped a few times, had to find out why. The worker's verification form had incorrect information. Having a hard time finding out about pension information. CCSI sent L&I a letter about pensions and they were not copied on the letter. Some calls returned but some not and not promptly. Attitude of case manager was poor (she was in the position of power and let you know about it). All of CCSI's work is geared toward denial. Residents being treated as a liar and a cheater. Payments become slower and slower until back to work and then all past payments are made promptly. This attitude comes from the DOE/CCSI and contractors. Calls are not returned or not timely, people are not courteous. Bills not paid timely because hospital said they were being "jacked around" by CCSI in their bills. CCSI has a problem whereby they conveniently lose documents frequently, but seem to be OK on paying medical bills. Calls not returned after 3 or 4 attempts. CCSI gives lots of excuses and his doctor won't work with CCSI anymore. CCSI misrepresented fact about his current treatment (said he was getting it when he was not). Doctors disagreed and the company disagreed with doctors. CCSI refuses to pay most (or ½) of the bills. When it comes to time loss 60%-70% of the time it is a nightmare dealing with CCSI. They don't pursue records.

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They might get 75% of what they need but will not then immediately follow up for the other 25%, they just ignore the missing records and get the Injured Worker to do follow-up. CCSI does return emails pretty well. Hard to get a hold of, but once you find a person to talk with its OK, but stopping an ongoing treatment was not helpful. Medical bill payment was OK, but calls and email not returned. At times CCSI can be nice but they are generally not helpful. Phone calls were returned promptly and until recently claims adjuster was very courteous and helpful. Bills were not always paid on time. Not sure what causes delay, believes bills have to go through 4-5 hands before adjuster deals with it. In one case, a treatment was denied because it was hard to explain the need for it, but finally it was OK'd. Phone calls usually returned after 3 days. Quit using phone calls after a certain significant difficulty involving not authorizing a specialist and started using emails. Claims adjuster was a "snot", but is courteous now because they are taping conversations. Not helpful because they wouldn't listen to him or his Attending Physician but would listen to company or company doctors (HEHF?). Once Independent Medical Examination supported diagnosis, payments were OK (not before). Some bills are very late (maybe 2 years old?). He believes the cause of the delay for approvals/bills was that they used the poor PA diagnosis (based on a 5-minute exam). Also consulted with a nurse on a bad report. CCSI pretended not to know about what the Attending Physician was reporting. Phone calls are returned, they are courteous but not helpful, at all, they protested that an exam took place, and used it in connection with chart note problems to deny certain TL. He has to take documents to them but they are never good enough, always want more. Thinks DOE has set up the TPA arrangements to take the company (contractors) out of it, and leave them with no ability to affect the outcomes. Phone calls not returned promptly and only some were returned at all. CCSI was initially courteous until the IW started asking questions. CCSI was not helpful. Certain bills were not paid on time, waiting for more information from Attending Physician, but eventually did get paid. Biggest concern was waiting 6-8 weeks to get approval for important diagnosis exam. The cause of the delay is they want to put enough roadblocks in front of Injured Worker so that they will lose interest and quit fighting. Phone calls were not returned, Injured Worker had to initiate all contact. CCSI contact has a very poor attitude. CCSI was not helpful. Medical bills were not paid timely because Injured Worker got collection agencies against Injured Worker. Not prompt, only about 20% of calls returned. CCSI was not courteous and were not helpful. Bills appeared to be paid on time. This is not an efficient system, CCSI need to communicate with doctor and claimant. Calls were not returned and emails stopped after a while. CCSI was not courteous and were not helpful. All Injured Worker received were negative responses. Bills appeared to be paid on time (no complaints from doctors but they knew it was a CCSI claim). Non-communication by CCSI, not told what to do, left hanging, creates frustration of Injured Worker because the delay can exacerbate the medical problem. Calls are not returned, not all bills were paid and several bills were sent to him for non-payment. CCSI is sarcastic: Injured Worker goes to supervisor and gets nowhere ("it's your problem"). No to all CCSI questions, except that after TL benefits started, continuing payments were timely. No to all CCSI questions (3 times) plus no medical bills were paid ever because of denial, Injured Worker had to pay own bills. No, the phone calls were not returned on time and they were courteous about half the time, were not really helpful but medical bills were paid on time. No to all CCSI questions.

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EEOICP Resource Center and Department of Labor:

EEOICP was great, paid claims pretty quickly. EEOICP is good. EEOICP had very good staff, very helpful, help you complete and file paperwork. Haven't communicated with EEOICP in a long time, not sure why. EEOICP has treated him very well so far. This person had an EEOICP claim filed 1 ½ years ago and hasn't heard anything yet. He found out about EEOICP by accident as they were at a company program talking about Beryllium and he pulled them aside to talk about his issue and they said come down to visit and they helped him with his paper work. He has a lot of problems, and his doctor and medicines are being covered by health insurance benefits, he hasn't talked to company reps, union reps or his doctor about W/C benefits. EEOICP has been extremely slow. Regarding EEOICP, nobody knows what the status is. The program is not that good because of the offsets, why are the two programs tied together financially like that? Local EEOICP people are good but after that, the process stinks, their job is just to deny claims. Bills paid through Federal System have been OK.

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L&I was helpful. L&I needs to go out to Hanford to understand the situation before they deny claims. Can't get a hold of L&I case manager, they never answer the 1-800 number and they don't use email. IW has no problems with L&I. L&I puts too much faith in CCSI and reliance on their doctor's opinions. L&I did their process the way they were supposed to. L&I is OK, as they send him copies of letters. L&I helped a lot, once they were involved, claims adjuster started doing things right but the correct outcome was not obtained. L&I was helpful in reversing a denial. L&I was helpful in one case but was unresponsive in others. L&I was helpful to the extent they could be (Injured Worker thinks they are limited in the amount of help they can give), they did steer Injured Worker in the right direction and did provided some advice. L&I only does their job when they are forced to.

We asked the question: Do you feel that you were prepared by training, correspondence, (such as brochures) or any other manner before the injury or illness occurred or did you learn the most about the process after you entered the claim process?

Random Selection Response:

Most individuals stated that they were not prepared for the process before entering the program. Selected representative comments along this line are:

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Had no idea. No, totally unprepared, quite an eye opener. No, "they" should give Injured Workers a heads up on process and what to do.

A few individuals stated that they did have some advance knowledge. Selected representative comments along this line are:

Company didn't explain process, but CCSI explained process to him before they sent him the claim form. Had a good idea in general that Injured Worker would face something from past experience and co-workers. Other co-workers helped Injured Worker out, gave some tips. When CCSI came in, they had meetings and explained what CCSI would be doing, so yes, this Injured Worker had some advanced information before the injury occurred. Sort of, trained on where to go for help, then employer representative explained the whole process ahead of time. Yes, this Injured Worker was involved for many years and was a manager, so this Injured Worker knew the process before filing a claim. He was prepared by having gone through it before, HEHF tries to help explain things, but CCSI doesn't. Talking to CCSI was helpful to a degree. Knew from a family member's experience that it could be a difficult process with lots of paper work.

Self-Selected Response:

There were some posters but not advanced training or brochures. Nothing provided, HEHF downplayed Beryllium. He did have some training through a union program and it did help him deal better with the process. The union can be helpful but an Injured Worker needs to know what to ask and find the right person. No, but did receive some paperwork once claim was filed. No training, believes there is a handbook but is written for HAMTC and not construction. No, there is a steep learning curve. No training, company reaction was hostile, had to write notes about the incident in front of a safety manager and the direct report manager, a stressful situation. No training, you learn from other people that have dealt with CCSI and learn as you go. No, but knew a little bit from previous L&I experience. "Kind of /sort of" not really told what to do by CCSI. Definitely not, very naïve, learned a lot. Even after 3 years still don't know process, but a lot of stress, out of work and loss of compensation.

Yes, from previous claim and L&I sent out a video on appeals process.

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SITUATIONS FROM RANDOM SELECTIONS:

Injured Worker Initiated:

Reported Injury to supervisor, went to AMH, brief exam, instructed to go see a doctor (this doctor helped with form and paperwork), who examined and did x-ray (didn't show much), doctor ordered physical therapy, after a while an MRI, then "state" approved surgery.

Noticed problem, co-workers encouraged Injured Worker to seek medical treatment, went to AMH, gave test, instructed to go see a doctor (they provided name), went to HR who provided claim number, paperwork and helped to set up claim, went to clinic for certain test, clinic submitted report to doctor and sent in with his PIR to CCSI, had surgery but not physical therapy, had TL for a while. Received a "closed" 100% rehabilitated letter; no compensation without any warning and Injured Worker disagrees with assessment (although Injured Worker believed doctor did state that).

Went to AMH, they recommended Injured Worker see Attending Physician, Attending Physician examined, helped out with claim paperwork and determined physical therapy was necessary (CCSI must have approved this because Injured Worker did receive physical therapy). Received a letter and a call from CCSI, after a while, physical therapy no longer necessary and claim was closed (never had any TL).

Since AMH is not open during certain shifts, had to go the ER, took x-rays told to go see Attending Physician. Not sure how claim form got filed either in ER or at Attending Physician, didn't get a copy. Returned to work with a restriction from Attending Physician and AMH. After a while, got letter from CCSI. After seeing Attending Physician a couple of times doctor said to close claim with permanent damage. Took about 4-5 months to close claim then 30 days and check was in the mail.

Next day after injury, he was stiff and went to chiropractor, gave exam, then to AMH. Both agreed on damage and the nature of the work restriction. Employee advocate got paperwork rolling and they mailed in the claim form. Received treatment as CCSI stated how many visits would be paid then treatment stopped, but Injured Worker was not better. Received a lot of confusing letters. Went to specialist on own and found out that Injured Worker wasn't going to get better and not going to get worse. CCSI arranged for an Independent Medical Examination and it was a joke. After Independent Medical Examination, CCSI sent Injured Worker to x-ray and MRI test. IW thinks results sent to Independent Medical Examination that reported that IW is not fine, definitely injured. After about 3-4 months CCSI sent Injured Worker to another Independent Medical Examination, which said there was no loss of motion and that Injured Worker was fine (Injured Worker disagreed with this conclusion).

Several different diagnoses over time submitted all at same time at encouragement of Attending Physician. Union Steward and employer representative (HR) helped fill out paperwork, Injured Worker kept a copy but HR sent in the form to CCSI, after not too long, had Independent Medical Examinations. One doctor was pretty concerned and gave a professional exam, the

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other two were not so good and one didn't treat Injured Worker very well. The most disappointing aspect of Independent Medical Examinations was that CCSI had not sent them Injured Worker medical files even after signing a release form. Concerned what kind of opinion and report will result when 2 out of 3 exams weren't very good, combined with no past history.

Went to AMH, in a couple of weeks injury wasn't getting better. Went to Attending Physician (somewhere in this process Injured Worker thinks that employer representative helped with paperwork). Attending Physician helped fill out paperwork. Had an MRI then Attending Physician sent Injured Worker to specialist (assumes CCSI pre-approved, never talked with CCSI, all contact was with employer rep), had another MRI. Did a little physical therapy. First Injured Worker heard anything from CCSI was a request to either go back to Injured Worker's specialist or see CCSI doctor to close out claim. Nothing had happened for a year and about the same time as this interview something happens (coincidence or not)? Had 2 MRIs of differing levels, should just go with most extensive type first to same time and \$.

Upon injury went with shift manager to AMH, they said you have an injury and recommended that Injured Worker see a doctor. They gave L&I forms and went to see specialist. Before seeing specialist Injured Worker filled out forms and sent them into CCSI. After Attending Physician exam, directed to go to physical therapy, which Injured Worker did for several weeks. Went back to Attending Physician who extended the time period for physical therapy visits for a few more weeks. After a while, Attending Physician recommended that the claim be closed and that there was no permanent disability.

Put claim in for Hearing Loss, noticed a problem and went to hearing center and received an audiogram, then went to doctor, who reviewed audiogram, did an exam and calculated the Hearing Loss. This Attending Physician instituted the claim and the Attending Physician helped fill out the claim form that was sent to CCSI. About 5 months later received letter from state L&I that they read the claim and awarded a monetary amount and hearing aid costs. CCSI said they hadn't gotten letter, this went on for about 3 weeks and then CCSI said they would appeal, but then didn't hear anything, so Injured Worker called L&I to find out what was going on, L&I stated that appeal period had lapsed. So then called CCSI who said they had changed their mind and wouldn't appeal. Injured Worker thinks that this was just a delaying tactic, they should have been more timely. Injured Worker had to make all of the contact, CCSI never contacted Injured Worker, especially Injured Worker expected contact about the intention to appeal L&I decision and then their decision not to.

Once injured, report to building emergency director and then to first aid (AMH or HEHF), they treated and discharged but didn't answer questions about what happens later on but before leaving, a nurse provided the claim form. Injured Worker filled it out and sent to CCSI. IW went to Attending Physician, who sent IW to specialist who did MRI but didn't cover entire injury. Disappointed with specialist conclusion that he didn't see anything wrong and was told that he was getting old. CCSI was pretty good, they followed up, it took some time, but they were proactive as they would call or send letters. On another matter HEHF made an error in their write-up of the visit (wrong side of body). Instead of pursuing a correction in documentation, CCSI denied claim because report was wrong (believes L&I was involved and agreed to close claim). After L&I involvement, IW decided to drop pursuing it and used medical insurance to deal with it.

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Didn't report injury right away, thought it would get better but it didn't, so for one to two (1-2) weeks he went to chiropractor got x-rays, exam then spoke to employer representative who suggested reopening the previous claim and to go ahead to doctor or specialist. Chiropractor filled out claim form and sent to CCSI. He wanted Injured Worker to go to physical therapy, physical therapy people called CCSI and they said that they wouldn't approve physical therapy because claim was under investigation. Treatment was not helping so went to Attending Physician (apparently this was a mistake on Injured Worker part). Not clear on timing of this. Got letter of denial and then a letter that it was under investigation then a letter accepting the reopening of a claim this all took about 3 months.

Went to AMH a couple of times when exposure occurred then they would say go see your Attending Physician and went to specialist, no one could come up with a solution and couldn't put finger on problem.

Injured Worker knew initial procedure, contact manager, who fills out problem report, go to HEHF, contact employer representative, who helps fill out claim form and gives out information packet. Employer representative did a great job of explaining how the process would work, the steps and options and rights of employee. Employer representative sent in claim form to CCSI and in about one (1) week got the form letter from CCSI. Attending Physician suggested a certain diagnostic test; conclusion of test was that a certain treatment was necessary.

Went out to sites for many years and came out with a positive beryllium LPT test. Filed claim just to document what had happened in case of future problems and because there was no current damage, understands why claim was denied. Nurse at HEHF provided claim forms, Injured Worker prepared them and sent off to CCSI, they responded that the claim was closed and denied, which Injured Worker understands and agrees with.

HEHF or AMH are polite, check him and if needed suggests going to Attending Physician, they will help him with the claim form and they are generally helpful. CCSI is confusing. HEHF tells Injured Worker to get a hold of employer representative, who tells them what to do. After a while CCSI gets involved then it's a confusing mess, Injured Worker gets frustrated, Attending Physician does also, going back and forth the on paperwork. CCSI is there to block claim and that is their attitude. Try to get out of the claim so that medical insurance can be used.

Had several different instances: generally AMH instructed Injured Worker to go back to work but was good about explaining option of opening up a claim now or later, instructed to visit employer representative and provided phone number, employer representative helps with paper work, calculates wages, gives a copy and sends to CCSI. CCSI sent several letters and phone calls, they are hard to get a hold of and he hasn't heard from them in a long time, so he is wondering why they aren't trying to close the claim.

HEHF referred to Attending Physician, provided medication and sent to specialists. Not sure whether it was HEHF or Attending Physician that helped with claim form.

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Pain in wrist, thought it might be carpal tunnel went to first aid (HEHF) Physician's Assistant (PA) saw Injured Worker, did more tests, then made referral to specialist & told Injured Worker to go to employer representative. HEHF offered work restriction, which employer honored. Employer representative explained process and helped fill out paperwork. CCSI approved the specialist visits and testing, results were that it was something else.

The workstation provided was inappropriate, which caused the injury. Complained for quite a while and finally went to HEHF and went to them for a long while until they said to go see own doctor. IW filed a claim with Attending Physician. Doctor and physical therapy bills were being paid. Prior to leaving work, Injured Worker closed the claim, as Injured Worker was getting flak from having to go to physical therapy and thinks this is why this Injured Worker was laid off.

Injury occurred before the end of the shift right before a three-day weekend. Supervisor asked if IW wanted to go to first aid but IW didn't think it was serious, so declined. The next day there was a lot of swelling and pain, so went to own doctor who treated injury. AP receptionist provided claim forms and had him fill them out. AP sent IW to specialist who performed diagnostic test and confirmed injury and that it happened at work. Received a letter, rejecting claim from CCS (apparently the employer wasn't accurate in the description of the incident, characterized it as happening in the parking lot after shift was over). CCSI never called to verify employer information. If they had, the matter could have been cleared up much more quickly.Appealed to L&I with correction of information provided, claim was accepted and L&I authorized treatment.

Claim was denied and it was slow but didn't appeal because it was better (easier) for IW's medical insurance benefit to handle it because no one else needed to approve anything. IW didn't understand what was going on and CCSI would call IW to have him go get reports, documents, etc.

Surprised to receive notice of interview because Injured Worker didn't pursue claim with CCSI because thought it would be easier to use medical health insurance for his injury. Injured Worker did submit claim form but didn't pursue after that.

CCSI wasn't bad, they wanted to know life history in order to work on his claim. He didn't follow-up on their requests, so Injured Worker thinks it was his fault that claim didn't progress or was denied.

Claim Initiated by External Organization or Other Means:

Claim started with an exit physical, HEHF took test, employer rep helped with state form, he mailed it in and it took 6-8 weeks to hear anything about the claim. CCSI said they couldn't use the test and Injured Worker had to find his own doctor to take a test. He couldn't find one that would take L&I claims. Finally found a hospital or clinic that would do a medical exam but not the test. Went back and forth about need for test several months (it took a year for his claim). CCSI then decided they would accept original HEHF records. CCSI told him they only do one step per month. He thinks they hoped he

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would give up. Once they approved claim CCSI told him he would have to find someone to dispense the equipment and they gave no contact names. Equipment doesn't work well.

Found out about hearing loss issue at company meeting. HEHF had notes about his hearing tests during annual physicals. Employee concerns person helped to connect Injured Worker to CCSI. CCSI sent him forms; he filled them out and sent back. Took a while for a hearing doctor appointment to be set up, more tests, and more paperwork, and then waited for a long time. Got a letter allowing claim and settlement amount, said it would arrive in a couple of weeks but took a lot longer and then "boom", the check arrived.

UW folks contacted Injured Worker, encouraged to file a claim based on their screening of HEHF files. So filed claim, had lots of physicals, UW contractor in local area helped fill out claim. CCSI ordered another series of tests; resulting conclusion was that problem was benign. On that basis, L&I denied claim. Because of this experience this Injured Worker had another issue that Injured Worker decided not to pursue, as it would be a waste of time. Believes beryllium issue gets most attention and other types of issues are ignored.

Injured Worker received a letter from HEHF about a union meeting in 2000 or 2001. Asked a lot of questions about where and when he worked, asked about beryllium, asbestos and radioactive material. Someone requested that he fill out a claim, which he did and he sent to CCSI. CCSI sent to specialist. Injured Worker doesn't know result, got a letter saying someone was taking over his claim. Got a lot of confusing letters, one stated that claim was denied then soon after, another letter stating that claim is still open.

HEHF never reported any issue about asbestos in his exams with them. Got a card from a university requesting he attend a paid visit to workers health in Kennewick. They did tests, x-rays etc., and found a problem. The university gave them several different questionnaires about work history. Injured Worker thinks university filled out claim form on his behalf. Got CCSI letter and went to Attending Physician then to specialist, scans, then a biopsy, specialist wanted to remove. From advise of Injured Worker's doctor, went to see another specialist other specialist disagreed with first and wanted to wait and see, which worked out. (Consultant's note- This IW was very happy about the state program claim process but got real fired up in the recommendation question about how he and others think unless you die or remove a body part you won't get compensated over and above paying medical bills, which may be a comment about the EEOICP program. He thinks that since he hasn't received any conclusions about permanent or partial disability and hasn't received any compensation payments it won't ever happen. It's just a dog and pony show put on by DOE. Perhaps there could be something that goes out to current open claims that explain legal benefits and what they should expect, especially for retired workers and individuals involved in this UW program).

Went to hospital, they discovered issue and suggested a certain diagnostic test at another hospital. The results were that the illness was work related. About the same time, got questionnaire from DOE offering testing for certain things, since already

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Knew Injured Worker had one positive result, they wanted to get testing for the other possible illnesses. Sent to specialist and another series of tests, positive twice. Somewhere along the line he was told to go see CCSI, they gave him paper work for him to take home and fill out. So got a claim # from CCSI and one from DOL and got a card. Had one billing problem otherwise it's working fine.

Didn't attend interview because he is fed up with this claim process. Filed claim because received a notice and forms in the mail stating that Injured Worker might be eligible for benefits (thinks the union sent this to them and that union filed the claim paperwork). This should have never been sent to him because of the Injured Worker's work history. Worked for so many different employers in and out of Hanford that it would be impossible to tie injury to any one place. Decided to file and had to take test. Final result was denial because couldn't determine that it happened at Hanford. Injured Worker could have told them that at the beginning. It was a total waste of time.

Had never filed an L&I claim, but received a letter for the UW with a questionnaire suggesting an exam. In hindsight it was a lot of hype. IW went to the Harborview appointment. The results stated that there was some hearing loss and a possibility of asbestososis. Then this IW got worried. UW helped to fill out claim because they said IW might want to check this out. A previous employer arranged for another hearing examination and Harborview performed a second lung test. Results were that there was no impairment in either case. This IW wonders why UW was set up to go through all of this just to verify that nothing was wrong?

CCSI is OK; they gave him an OK on three different things. Injured Worker thinks CCSI took care of things but doesn't know for sure. The companies were very bad, destroyed records, they used and abused them (workers). Been fighting state about bad records.

Several years ago IW began receiving postcards or flyers in the mail and ignored and discarded the notices. After several years of this, IW eventually decided to engage in the process. The program was from the University of Washington related to ex-Hanford workers. IW went to Harborview to get tested for hearing loss and cancer. Tests showed hearing loss has occurred, but the problem is determining how and where it happened. Nurse suggested that IW may qualify for a claim and told IW how to file a claim. IW believes that UW staff may have provided the claim form to him.

Comments Regarding EEOICP:

Has a B and a D (now E) claims in with EEOICP. DOE denied claim and appeal was denied because less than 51% exposure causation rating (by NIOSH) to receive benefits. Type E is ongoing and Injured Worker is in limbo. EEOICP told IW that they would send a formal letter every six months. Was told they were only dealing with deceased people right now (he had earlier been told that his claim would be one of the first). Injured Worker can't get old exposure data. Apparently it is available but you need to search for it yourself but you need to know the year and month that the exposure occurred, most people won't

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know these specifics. When he did receive some new information and sent it to DOL, the Case Worker in Seattle got mad at him (the 6-month form letter comment came out of that).

He didn't remember much about state L&I case (CCSI was just doing their job but they weren't helping him) but has some experience with DOE refusing to grant his request for a full body scan. Battelle can't help him any more, DOE never responded.

Got cancer and Medicare and own medical insurance paid for treatment. There were 4 of them at Hanford, 3 have died of cancer and IW has cancer. While got a card from DOL for future medical bills, got letter stating claim was denied. This is in spite of the Attending Physician's report that cancer was caused by working at Hanford. Letter stated that a positive physicians panel under EEOICP accepted and claim turned over to CCSI. Received a letter saying the program was switching from DOE to DOL; they said they would pay \$150,000 but everyone they talk to say they were turned down. He used to be provided periodic physicals but then they just stopped. The test results he had were negative. He wants more tests but is waiting for "them" to call him. Surgery guy took care of everything. EEOICP closed claim, IW sent a rebuttal but he was denied. Was DOE then DOL, why send a DOL card to pay future medical bills (they see this as taking responsibility) and yet deny claim? People are turned down, no \$ to widows, why say there is the \$150,000 program if you are not going to pay it?

In connection with the UW program and result of tests, became involved in EEOICP program, and it continues to be open.

SITUATIONS FROM SELF-SELECTED (VOLUNTEER) GROUP:

(NOTE: It appears that most, if not all of the self selected group self-initiated the claim. However, it is possible that certain external influences exist that were not captured in these interviews. As such, these situation descriptions are provided without a sorting similar to the random group provided above.)

The claim started out very slowly, was shuffled around between L&I and CCSI. Took quite a while to get a claim number and then about two months to get a letter saying medical and time loss will be paid. The SIF-5 was incorrect regarding wages, fought for 2 years to correct it. Don't believe CCSI contacted Fluor for wage information. He didn't receive copies of letters. Asked CCSI to approve a specialist but didn't happen. First Independent Medical Examination Report confirmed eligibility but believes CCSI hounded the Independent Medical Examination to change report to deny, but Independent Medical Examination had no background information, no files, documents and performed no testing. IW's doctor said that bills were not being paid.

CCSI pays medical bills very late. There are only a few vendors in the DOL side because of electronic billing and other regulations the doctors don't like. DOL needs more vendors in program. CCSI tends to "lose" documents; there is a lot of

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resending documents. It seems as if there are long delays because CCSI requests information from doctors and others in a piecemeal fashion, asking one question at a time and not a comprehensive request document. If the doctor's wording is not exactly what CCSI wants (or needs), they challenge doctors. Preauthorization process takes too long. IW expects that it is a delay tactic. CCSI stated that they could use personal (health) insurance but not true as most won't pay until a determination about L&I benefits is determined. Believe DOE uses CCSI because L&I is "too expensive". CCSI is there to save DOE \$. CCSI tries to close claim too quickly to receive payment under their contract. However, ongoing medications need continuous monitoring, so they keep submitting to make sure they don't lose benefits.

DOL is good at payments and reimbursements, as they don't require horrible paperwork. Had to hire an attorney for DOE/CCSI process. Believes DOE has paid \$4 million in legal fees to keep from making payments.

Had to go through HEHF and then through CCSI getting claim validated, they (both) reject everything. Going through a respected hospital first, to get a correct diagnosis is important otherwise everything will get rejected. One Independent Medical Examination found a positive result, while two others were not good, not competent, i.e. did not get examined.

HEHF said he could not have disease, but after a private medical review and involvement of a specialist and more tests, the conclusion was not so sure. An Independent Medical Examination used a CT scan and results were included in letter from L&I approving claim.

Company did help but was told incorrect information (didn't need to file a L&I form) by safety/first aid.

No contact from company or CCSI about whether status reports, etc. were current. After a while a letter and a call from CCSI asking whether the private doctor agreed with Independent Medical Examination (Believes some back and forth between Independent Medical Examination and CCSI was for purpose of modifying opinion). Closing claim settlement came with a payment schedule that didn't get started on time, a lot of CCSI excuses. Received a CCSI letter disputing claim to L&I, then L&I found in Injured Worker's favor.

Requested file copies from CCSI, they were poorly organized and certain omissions were not proper.

Diagnosis was confirmed, put on work restriction and was off work for weeks without pay.

Advanced Med said light duty OK, got worse, went to personal doctor with tests, kept on light duty, another MRI, and then couldn't continue at all. CCSI in investigative stage, so a long time waiting for first payment, CCSI lost paperwork.

2 claims, one took 8 months the other took 14 months until fully paid (some interim payments were made.) CCSI frequently decides to disagree with doctor opinion, will get consultation from an expert and then disagree with that. Usually the consulting opinion agrees with IW's doctor opinion.

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CCSI sent email to stop treatment that had been happening for a while until they approved it. Doctor was upset that CCSI was practicing medicine. CCSI tries to close claims before they are complete. Biggest complaint is that CCSI opens, reopens and closes claim as they see fit without considering doctor's opinion. He is funding physical therapy on his own (IW uses medical insurance).

CCSI said that IW couldn't reopen a claim even though something new popped up that related to a past injury (IW doesn't think that is correct or perhaps shouldn't be correct). HEHF hassled IW's doctor to release him for work (per his doctor's statement) finally doctor gave in to pressure. In process of requesting a close to L&I, CCSI set up an Independent Medical Examination that was very poor. Conclusion was that he was fixed and stable when in fact he has never been fixed and stable since the injury. All Independent Medical Examinations (there were several?) were a "company paid" doctor hired to tell CCSI what they want to hear. Private doctors won't deal with CCSI (per comment made by a medical office receptionist). It took many months to schedule an Independent Medical Examination to support a doctor's opinion for surgery, no communications of outcome of Independent Medical Examination or surgery approval for several months. One time, CCSI approved the claim, paid medical bills and then requested a denial to L&I. L&I allowed claim.

HEHF did not run any PFT or x-ray tests and after getting worse over time, doctor and specialist were able to diagnose it as work related. Because there was a couple of different observations and diagnosis on same form, this caused confusion (doctor was away from office and couldn't answer questions for a while) so it took 5 months to approve claim.

If you have a doctor that knows how to write up notes it helps move the claim along more quickly.

CCSI has been good on this claim until recently due to change in personnel. Shouldn't argue about a qualified specialist or where they are located.

HEHF reported a normal exam when they shouldn't have. Company sent to special exam at their expense.

Supervisor went with IW to AMH then went to emergency room (excused him from work for three days). Reason IW went to emergency room is that IW called around to doctors and couldn't find one that would take an L&I case. Finally found one. Doctor didn't keep restriction current (ran out of proscribed time before next exam) this caused time loss to be denied along with problems in chart notes.

AMH did some tests and sent back to work. Employer rep helped with form but IW filled it out and sent it in without the doctor's potion. Then went to doctor, who recommended a scan with a note to CCSI, but they stopped it and took 6-8 weeks to approve procedure. Medical providers were not paid and Injured Worker was told that they were treated rudely or told that CA was on vacation several times. Independent Medical Examination was a horrible experience, it was a painful exam, and when complaints were expressed, was told that if they didn't cooperate the claim would be viewed as fraudulent. Independent Medical Examination wanted a list of all doctors seen during entire life (was this necessary?), quizzed about the

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file, bullied. Result of Independent Medical Examination stated that there was no medical problem (don't agree). Once the Independent Medical Examination report was received, the claim was closed.

HEHF agreed that it was a work related injury and helped with the claim form. Once Injured Worker contacted CCSI it was a "nightmare". His doctor won't deal with CCSI anymore. CCSI wouldn't pay for prescriptions, denies payment, they 'screamed and hollered" and stated that Injured Worker was just old. CCSI said they would reimburse for a diagnostic test and then denied payment. Had to call L&I and once they were involved, payments were made. Certain payments went to collection from Injured Worker because CCSI didn't pay for a long time. Independent Medical Examination was a "quack" and his Attending Physician agreed. Independent Medical Examination exam was only 10-minutes, but he was x-rayed. Independent Medical Examination conclusion was that nothing was wrong, which disagreed with Attending Physician. After a long wait, claim was denied. Doctor recommended surgery, but CCSI wanted to reimburse insurance company (medical benefits). This person also had a more recent claim that did not require an Independent Medical Examination, surgery was OK'd and claim was accepted promptly and bills are being paid. (Wonders why there was such a difference between the two different claims?)

HEHF did take x-rays but not good advice. However they did suggest going to own doctor. Doctor helped do paperwork. Doctor gave advice on how to help issue and Injured Worker kept going to doctor. For 6 months there was no communication from CCSI and they didn't direct him to a specialist but then they allowed the claim. Sent to two (2) Independent Medical Examinations: One supported original diagnosis and that treatment was overdue; the other provided an opinion that it was OK and problems were from some other cause. CCSI picked the opinion that favored them. Within two (2) months after that, the claim was closed. CCSI never directed Injured Worker to therapy.

This Injured Worker had a documented "incident" (which seemed to help). After a HEHF exam and an ER visit, employer representative helped fill out claim paperwork (he worried about the employment impact of opening claim), went to a specialist and was put on medicines. Three different specialists were scheduled one month ahead of time, but he was informed one hour before a scheduled appointment that CCSI might not pay for it (increased stress level a lot). CCSI switched staff, and the new person was very mean. He got HR and other employer reps involved. Company management was very willing to help and met with CCSI, but they (CCSI) lied during the meeting and then denied their statements. CCSI had no medical qualifications but they make medical decisions. Their attitude is that they are in control and there is nothing you can do about it. Took months to schedule an Independent Medical Examination in a distant location. The Independent Medical Examination was a decent exam. Independent Medical Examination report confirmed Attending Physician opinion. Independent Medical Examination had access to entire file. Once accepted, all doctors got paid.

HEHF (this happened a long time ago) misreported incident then denied that an earlier visit took place. (Consultant's note: This was a pretty horrific story in regards to the severe and immediate health impacts). Independent Medical Examination gave an "all OK" report so L&I denied the claim. In 1984-1985, L&I confirmed there was a cover-up of radiation exposure,

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but statute of limitations had run out to file a claim. Doctors and Independent Medical Examinations provided differing reports on asbestos. The experienced pulmonologist saw Plural Plaque in lungs from a CT scan, but the inexperienced Independent Medical Examination didn't look at the scan and reported nothing in lungs. Thinks his specialist was later "bought off" because he changed his opinion. CCSI is very rude (said "so what"). Special committee that reviews asbestos is supposed to have 7 doctors but in his case there were only 6 and they tied, so claim denied.

One person received an EEOICP settlement, but since 2001 no word from CCSI regarding claim for Part B. The other IW also has a claim outstanding since 2001. (Consultant's note: think these IW's are most upset that lots of people have been exposed and no one has ever taken responsibility or let them know what they were exposed to. Lots of widows and who is going to take care of them?)

There are many exposures to chemicals in several sites, Battelle did tests at the tank farms in 1987 and found that certain vapors and chemicals were 3 times over the OSHA limits at the time. After an exposure, go to HEHF and report symptoms but there were no tests or exam given and they may not have documented the visit (sign-in log). Even doctor exams may not have been documented before 1992. Even then, there were job hazard ratings for certain areas with an assessment of multiple chemicals and unknown carcinogens but no testing related to chemical exposure performed when he reported to HEHF. So now, the only way to prove exposure is from other people, not medical history. Injured Worker believes doctor was pulling notes out of the file because when Injured Worker requested copies of medical file, observed that notes were not the same as when the exam took place. This claim was denied because they couldn't prove exposures occurred. Never had a problem with L&I before, because they would tell you up front how to handle and manage your own claim. CCSI would leave a message and then never return calls. Employer rep used to be good at getting CCSI attention but new one is not good at following through with CCSI. Injured Worker believes that DOE is responsible for ill health of Hanford workers and should be responsible for proper medical treatment, etc.

Injured and went to first aid (HEHF?) then was taken to ER for x-rays. CCSI contacted Injured Worker to inform that they were discontinuing payments because doctor hadn't given them the required paperwork to continue payments. This was very frustrating being stuck in the middle between a frustrated doctor (about what they are asking for) and CCSI. Doctor didn't think Injured Worker should return to work but didn't want to fight with CCSI anymore and thought if a light duty job was available it might be OK to return. Did PT, but after several months the condition became real bad and he stayed home. He went to doctor, who provided a note that said the IW needed to change work activity, got a note from employer representative that no compensation for days off unless CCSI got a better note from Attending Physician. Attending Physician suggested a clinic, but the suggested treatment was turned down as being too expensive. Had Independent Medical Examination, it was a joke, reported that treatment was not needed. 2nd Independent Medical Examination (forced into it by legal representation) confirmed the Attending Physician's suggested treatment. Finally got treatment and it worked. Injured Worker really bothered that he was forced back to work by CCSI before Injured Worker was ready to return. Also upset that CCSI wouldn't answer questions. Believes CCSI, the companies and Independent Medical Examinations are "in bed" together and want to get you back to work so don't have to report TL accident.

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Had chemical exposure and had to go to own doctor to fill out claim, it's a CRI claim and should be a Part E claim now. Had several exposures but just two claims that CCSI combined into one claim. CCSI will not accept paperwork for chronic toxic exposures or occupational asthma. Shouldn't have been on LT disability for a work-related injury but was. Employment terminated while on LT disability, believes this act was racial and gender discrimination. Attending Physician reported that illness is work-related but Independent Medical Examination disagreed (this Injured Worker thinks that the Independent Medical Examination is in "Cahoots" with attorney). The claim was denied in appeal process.

Was exposed to both toxic chemicals and radiation, CCSI denied the claim, but L&I reversed the decision, employer is appealing. Thinks that workers are having to pay all medical costs, significant travel and lots of attorneys fees out of their own pocket to fight against CCSI and employers, although, in this case, L&I is providing legal representation (AAG).

Exposed to chemicals, HEHF suggested to open an L&I claim but didn't right away and then another exposure and wanted to open a claim and HEHF denied their previous statement recommending an L&I claim and suggested not opening a claim. Received a heavy metal test, which indicated an issue. After 3rd documented exposure, HEHF said go back to work. Employer representative said Injured Worker had chemical sensitivity but went back to work at same job anyway. Another test and the issue was worse so Attending Physician took Injured Worker off of work, claim filed, CCSI denied, didn't believe it was a plant related illness. Independent Medical Examination agreed with Attending Physician that Injured Worker can't work around chemicals or radiation, since that time have heard nothing, CCSI won't give a status report. Finally, the claim was accepted on a conditional basis. The problem is that no TL has been paid (since has left employment) and can't get unemployment insurance because it's a WC claim.

Injury occurred, reported to supervisor and reported to HEHF as soon as possible. HEHF asked if Injured Worker wanted to file a claim. Attending Physician and specialist ordered MRI. Attending Physician and specialist's opinion was consistent with HEHF opinion. CCSI approved specified treatment.

Got frustrated with this claim process and gave up. Initial diagnosis didn't indicate injury/illness but got worse, then filed claim. Diagnostic test given was negative because it would only show as positive when symptoms were present at time of tests. Injured Worker asked to return when symptoms returned. Change of personnel at CCSI and a "closed" letter arrived and the reasons stated that the claim not valid, as it was not work related. CCSI stated they had not received paperwork providing evidence of work relatedness, but they had been provided the paperwork. Dropped pursuit of appeal because couldn't afford a lawyer.

HEHF examined and treated exposure. Chart notes clearly stated a reaction to chemicals and to be taken home immediately. (This Injured Worker believes there are two sets of chart notes, one in handwriting and another different set entered into computer for reporting purposes). ER couldn't make a diagnosis because of the elapsed time. Had a bad interaction with employer representative (threatening placing hardships to make compliance very difficult) CCSI tried to deny claim, L&I reversed it, but still TL payments weren't being paid.

Appendix D: Scope and Methodology

Introduction

L&I has generally established the scope of this performance review project in our contract. In consultation with L&I project management, we have made refinements to the scope of work as the project progressed. This Appendix D describes the project requirements, objectives, limitations on the scope of work and the work that was conducted.

Background

Workers at the Hanford Nuclear Reservation site have expressed concern to the Department of Energy (DOE) that claims for workplace injuries are taking too long to process. Workers complained of having to hire attorneys to attempt to get some medical claims paid. Other claims, they alleged, were languishing for more than a year before being paid. DOE committed to a review of the third party administrator, Contract Claims Service, Inc. (CCSI) that handles their workers' compensation claims. At issue is whether CCSI is processing the claims as required by state law and doing so promptly while treating employees with courtesy. In order to conduct the review with objectivity and ensure the results and recommendations are fully credible to the employees, DOE requested that L&I manage the review process. The agencies have determined that hiring an independent vendor to coordinate the review would be beneficial and increase the credibility of the review.

Scope and Project Objectives

L&I issued a Request for Qualifications and Quotations (RFQQ) dated November 15, 2005. This RFQQ stated the project purpose as follows:

"...conducting a performance review and analysis of the Department of Energy's (DOE) process for adjudicating workers' compensation claims at the Hanford Nuclear Reservation.

The services include the following:

- Review the reliability, integrity and the efficiency with which resources are employed for adjudicating workers' compensation claims;
- Conduct and analyze interviews with Hanford workers who have filed workplace injury and illness claims;
- Identify possible problem areas and provide suggestions for improvement."

The scope of this project includes all workers' compensation processes at Hanford necessary to provide the following as is required by our contract.

"A clear explanation of the current status of the workers' compensation system at Hanford, including claims process flow charts for a range of claims types and their overlapping and complementary jurisdictions – i.e.,

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DOE and its third party administrator; L&I; and, via a separate program (the Energy Employees Occupational Illness and Compensation Program), the federal Department of Labor."

As such, we will consider all processes and entities involving the administration of injured workers' compensation at Hanford to be included in the scope of work. However, for selected project tasks we will use a more narrow scope of our review. The random selection of employees that we will interview and the claim files we will review is limited to only those new claims processed by CCSI during the year ended December 31, 2004.

The project requires the independent contractor to address and include the following in its final report:

- Overview of the methods used.
- A clear explanation of the current status of the workers' compensation system at Hanford, as discussed above.
- An assessment of whether DOE is meeting the standards for injured worker protection under the laws, regulations and policies governing DOE's role as a self-insured Washington employer,
- An analysis and suggestions for areas of best practice and process improvement that could enhance clarity, communication, timeliness and injured worker satisfaction,
- Summary of findings and recommendations,

Project Methodology

The information necessary to provide the required information and analysis was obtained through interviews of workers, who have filed claims during the year ended December 31, 2004, other self-selected workers and a review of the CCSI's claim files. We interviewed CCSI, DOE and their contractors, and DOL staff who are directly involved in the various processes to enable us to provide a clear explanation of the current status of the workers' compensation system at Hanford. We also interviewed other entities involved in the process such as the EEOICP resource center and the US Department of Labor and the University of Washington's Former Hanford Workers Monitoring Program. We documented the current system using flowcharts with additional narrative explanations in Appendix A.

We used the standard sample size formula for determining the required sample for employee interviews and claim file reviews. To the greatest extent possible we used the same sample for both interviews and claim file reviews. However, the file review procedure did not accompany the self-selected interviews because the interview was not a result of the random selection. This situation involved dates of injuries that are outside of the scope of our work established by L&I. In addition, some workers who have subsequently left employment and current workers that were randomly selected for a claim file review did not participate in an interview for a variety of reasons.

We selected an initial random sample of 65 claim files, which is in excess of our minimum requirement of 48 to manage possible testing results that might

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adversely affect our ability to provide statistical conclusions. Our methodology regarding the sample selection is more fully described in this Appendix.

Significance and Users' Needs

This program directly affects persons needing vocational rehabilitation due to workplace injuries, injured employees, and dependents/other participants/beneficiaries in this program. This program also impact groups such as employers and labor organizations.

While all groups have varying degrees of interest in the results of this project, we believe the primary user of the information, analysis and conclusions developed in this project is L&I management. L&I's perspective is one of an oversight regulator to determine whether DOE is meeting its requirements as a self-insured employer under the applicable laws, regulations and policies.

This project focuses on how well DOE and its third party administrator CCSI is managing the workers' compensation system at the Hanford Nuclear Reservation. As such, the DOE and CCSI are significant users of the results of this project. The DOE and CCSI perspective is one of program administration. Their needs are more management and process related. They should obtain more specific information about the results of the project, that the results are factually correct and properly described, and that the recommendations are feasible to implement.

There are other groups, such as labor organizations and advocacy groups that have an interest in the results of this project. Their perspective is one of addressing employee issues encountered from their participation in the workers' compensation system.

Results are presented to inform L&I decision-makers as well as providing recommendations to those responsible for managing the program. The results should also be useful to allow advocacy groups to understand the context within which individual issues can be considered.

Understanding the Programs

We held preliminary meetings with representatives from L&I and discussions with DOE and stakeholder groups to obtain an initial understanding of the programs and issues that we may wish to consider in the scope of this review. In addition to the preliminary interviews, we obtained certain (but not all) relevant statutory requirements.

We obtained an initial indication of the volume of new claims filed during 2004. This information allowed us to do research on the appropriate sampling plan and sample size determination. The results of this research and related judgments are more fully discussed in a later section of this Appendix.

Criteria

The criteria for randomly selecting employees for interviews and claim files is directly related to the time period of the year ended December 31, 2004 selected by L&I. Any new claim during this time period had an equal chance of being selected for review. In addition, we allowed for interviews of self-selected employees, who expressed a desire to be interviewed. However, we did not extend the file review procedures to these employees.

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The criteria used to determine whether the system is operating properly are several-fold. The first level of criteria is the rules and regulations related to self-insured employers issued by Washington State. The second level of criteria is our understanding of sound business practices and industry standards. The third level of criteria is the policies and practices of CCSI in managing the DOE's claims administration system and the rules, regulations and policies related to workers' compensation management issued by the DOE and its contractors. These criteria levels are not mutually exclusive, as many of the DOE policies are reflected in the CCSI policies, which in turn reflect L&I's policies and sound business practices.

Details of Interview and File Review Tasks

Since a major portion of our effort was devoted to interviewing injured workers and review of the CCSI claim files, we have provided additional detail as to how we approached these tasks. A key planning decision is the size of the sample of employees to be interviewed and claim files to be reviewed. The requirement contained in our contract is as follows: "The contractor shall establish a statistically significant random number of employee interviews to be conducted in order to achieve at least a 90% confidence level." The Request for Qualification and Quotations, including amendments suggested that a sample size of 60 would be sufficient at a 95% confidence level (please note that the suggestion of 60 sample items uses a confidence level in excess of the required 90% level).

To determine the appropriate sample size we used the following commonly used formula.

$$\text{Sample Size} = n / [1 + (n/\text{population})]$$

$$\text{In which } n = Z^2 [P(1-P)/(D^2)]$$

P = True proportion of factor in the population, or the expected frequency value

D = Maximum difference between the sample mean and the population mean, or expected frequency value minus the worst acceptable value

Z = Area under normal curve corresponding to the desired confidence level

In order to use this formula, certain information (such as size of population) and judgments (such as expected rate of compliance) are required. We obtained the population of new claims filed during the year ended December 31, 2004 (see discussion of time period below) from DOE.

While we used the same random selection for employee interviews and the claim file reviews, the purpose of these activities are different and such difference needs to be understood and addressed in the sampling plan. The employee interviews are "discovery" in nature, whereby open-ended questions explore the employees' perceptions of the process in addition to specific incidents. In this situation a judgment about the expected frequency of a certain type of comment cannot be prejudged. This is in contrast to a file review whereby compliance with quality assurance procedures is normally expected to be high. This judgment affects the value to be placed for "P" in the formula above. Similarly, the amount for "D" would need to anticipate a large precision level for interviews and a more precise sample for claim file reviews. To address this issue of the different nature of the sampling objectives, and therefore, the need for a certain sample size, we used the case that calls for the largest sample size.

We used the following information and judgments for a claim file selection in applying the formula.

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P=95% (this is the expected compliance with the attributes, discussed in a separate section below, in the population).

D=5% (we have determined that the "tolerable rate of error" is 10%, therefore the "precision" is the difference between the 95% expected compliance rate and the 90% tolerable error).

Z=1.645 (this corresponds to the 90% confidence level)

Population = 560 (provided by DOE officials)

The result of calculating for "n" is:

$$\begin{aligned} n &= 1.645 \times 1.645 [(0.95 \times 1 - 0.95) / (0.05 \times 0.05)] \\ n &= 1.645 \times 1.645 [0.0475 / 0.0025] \\ n &= 1.645 \times 1.645 [19] \\ n &= 1.645 \times 31.255 \\ n &= 51.41 \end{aligned}$$

Solving for sample size (S) is:

$$\begin{aligned} S &= 51.41 / [1 + (51.41 / 560)] \\ S &= 51.41 / 1.0913 \\ S &= 47.09 \text{ or } 48 \end{aligned}$$

In summary, a sample size of 48 provides for a statement that we are 90% confident that the compliance rate of the population is between 90% and 100% (precision level of 5% around the expected compliance rate of 95%).

Using this formula in the context of employee interviews assuming that 80% of interviewed employees will not express problems with a tolerable acceptance rate of 70%, yields a sample size of 41.

There are a few issues with using sampling techniques in this project that are important to note. As is indicated in the section below regarding the attributes for the file review, most attributes did not apply to every claim. The actual tested sample for any specific attribute fell below 48 for most attributes. As such, the evaluation of the results does not provide the same statistical statement. Likewise, the compliance rate of the sample for many attributes fell significantly below the expressed tolerable rate, and therefore, a meaningful "achieved upper precision limit" was not obtained. These situations did not prohibit us from forming conclusions about the performance of the claims administration process, but they prohibited a meaningful statistical statement within a useful precision level.

It is important to note that the project is designed to "assist L&I in its review of the workers' compensation claims process currently used by the Department of Energy (DOE)." This is an important distinction because L&I has determined the time period for the claim file review. Due to the time lag for reporting and administering claims, L&I believes using the calendar year 2004 provides the most complete claim files and yet are relatively current to address the current processing environment. We contacted CCSI to determine the numerical sequencing of their claims for purposes of running a random sample as required for this project. They use a system generated claim identification number to track claims in their system. Using the beginning and ending numbers of these forms used during 2004, we were able to determine the population of claims for

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the year. Using the random number generator function in Excel, we applied the random numbers to the claim number population for the claims selected, and therefore, the workers subject to the interview process. The claim numbers selected were provided to CCSI (through DOE) so that they could provide DOE and us with the employee names for DOE's scheduling and our interview purposes.

We obtained summary level information regarding the relative percentages of the major categories of claims (e.g. time loss, medical only, etc.) for the year ended December 31, 2004. We also prepared this same information for the sample selected. We compared the two sets of summary total percentages to determine how closely the sample represents the population. Our analysis is provided in our report. Based upon this analysis, the sample selected appears to be representative of the population.

Interviews

We obtained an initial series of interview questions from L&I. We understand that DOE staff developed these initial questions. We proposed several modifications to the initial interview form and received L&I's approval prior to conducting the interviews.

We protected the confidentiality of individual comments. We initially documented our notes from the interviews manually on the interview form and additional hand-written note pages. We summarized these notes in a Word document. We summarized the interview comments in such a way so as to not allow any specific comment to be attributed to any specific individual. We categorized the nature of the comments along logical process component categories. The summary comments categorized by nature were provided to all interview participants so that we can determine whether the summary provides an indication or conclusion that is consistent with individual comments. This also provides a quality control procedure to assure that our notes are reasonably accurate in relation to the information that the participant wished to provide.

Claim File Review

Claim files were provided by CCSI in hard copy form. All required information was contained in these hard copy files, and therefore, access to the CCSI claims administration system was not necessary. We developed an attribute-testing document that was used for the claim file review. The listing of attributes and the file review results are provided in Appendix B.

During the course of the claim file reviews we accumulated the results for each applicable file review attribute on an Excel spreadsheet. This was used to track and report progress of the project and was used to include the summary results in our final report.

To the extent we required clarification or assistance regarding the self-insurance rules and regulations, we requested assistance from the Self Insurance Program Compliance staff assigned to this project. For all claims involving chemically related illness claims, we received assistance regarding the review the file with the CRI Unit staff assigned to this project.

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Process Documentation and Analysis

One of the several aspects of the written analysis and final report as contained in our contract is to provide "A clear explanation of the current status of the workers' compensation system at Hanford, including claims process flow charts for a range of claims types and their overlapping and complementary jurisdictions – i.e., DOE and its third party administrator; L&I; and, via a separate program (the Energy Employees Occupational Illness and Compensation Program), the federal Department of Labor."

While certain information necessary to produce this explanation, including claims process flowcharts was obtained through the worker interview and claim files reviews, the bulk of this information was obtained from interviews with CCSI, DOE and their contractors, and L&I staff who are directly involved in the various processes. We also interviewed other entities involved in the process such as the EEOICP resource center and the US Department of Labor and the University of Washington's Former Hanford Workers Monitoring Program. We documented the current system using flowcharts with additional narrative explanations in Appendix A.

As a quality control procedure, we provided the process documentation to those individuals who provided the information to determine its accuracy and revise them as needed.